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## PROVINCE OF ONTARIO

*[Commission and committee of inquiry]*

### THE MEDICAL SERVICES INSURANCE ENQUIRY

Proceedings of the Public Hearings  
held at the Galbraith Building,  
University of Toronto,  
Toronto, Ontario, at 10:00 a.m.  
on Tuesday, January 21st, 1964.

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VOLUME

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DATE

January 21, 1964



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OFFICIAL REPORTERS  
TORONTO, ONTARIO

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T. Goldberg  
J. Sparks

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COBALT, ONTARIO

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VERBATIM REPORTING  
SERVICE  
TORONTO, ONTARIO

607

1 --- On commencing at 1 PROVINCE OF ONTARIO

2 MEDICAL SERVICES INSURANCE ENQUIRY

3 SUBMISSION OF THE CANADIAN REGION, INTERNATIONAL

4 UNION, UNITED Proceedings of the Public AGRICULTURAL

5 Hearings held at the

6 IMPLEMENT W Galbraith Building, Univer-

7 sity of Toronto, Toronto,

8 Ontario, at 10:00 a.m. on

9 Tuesday, January 21st, 1964.

10 T. Goldberg

11 MEMBERS OF ENQUIRY:

12 Mr. J. Sparks

13 Dr. J. GERALD HAGEY -- Chairman opportunity to

14 read the state Mrs. J.A. AYLEN ions there?

15 Dr. WILLIAM BUTT just in the process of doing

16 that sir. Miss HELEN CARPENTER

17 Mr. DALTON J. CASWELL you care to introduce those

18 who are assist Mr. A. ROY COULTER sentation Mr. Burt? I presume

19 that you are to Dr. R.J. GALLOWAY that right?

20 Dr. JOHN HAMILTON r. Chairman. Do we stand or

21 sit? Mr. W.S. MAJOR

22 Miss HELEN McARTHUR make yourself comfortable and

23 remain seated. Mr. P.J. MULROONEY stand.

24 Mr. CARMAN A. NAYLOR introduce myself first, if I

25 am permitted. Mr. HARRY SIMON t, the Canadian Director of

26 UAW, United Aut Mr. J.L. WHITNEY of America and to assist me, and

27 to assist you, Mr. L.E. TURNER present -- Secretary on my right

28 Dr. Ted Goldberg, and on my left Mr. John Sparks, both of whom

29 are health care consultants ----- International Union of the





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Proceedings of the Public  
Hearings held at the  
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Tuesday, January 22nd, 1964.

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Dr. WILLIAM BUTT

Miss HELEN CARPENTER

Mr. DALTON J. CASWELL

Mr. A. ROY COULTER

Dr. R.J. GALLOWAY

Dr. JOHN HAMILTON

Mr. W.S. MAJOR

Miss HELEN MCARTHUR

Mr. P.J. MURDOON

Mr. CARMAN A. NAYLOR

Mr. HARRY SIMON

Mr. J.L. WHITNEY

Mr. J.E. TURNER -- Secretary

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UAW and attached to our Social Security Department.

1 --- On commencing at 10:00 a.m.

2 THE CHAIRMAN: Do you wish to proceed?

3 MR. BURT: We appreciate the opportunity to  
4 SUBMISSION OF THE CANADIAN REGION, INTERNATIONAL  
5 UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL  
6 IMPLEMENT WORKERS OF AMERICA - UAW

7 Appearances: George Burt

8 T. Goldberg

9 Mr. J. Sparks

10 THE CHAIRMAN: Have you had an opportunity to  
11 proper level and extent of the responsibilities of government  
12 read the statement on instructions there?

13 MR. BURT: I am just in the process of doing  
14 we hope you will seek in your studies and deliberations to face  
15 that sir.

16 THE CHAIRMAN: Would you care to introduce those  
17 the government functions, financial responsibilities and relation  
18 who are assisting you in your presentation Mr. Burt? I presume  
19 ships which are inherent in Bill 163. In these introductory  
20 that you are to be spokesman. Is that right?

21 MR. BURT: Yes, Mr. Chairman. Do we stand or  
22 the role which would be assigned to government in these areas,  
23 sit?

24 THE CHAIRMAN: No, make yourself comfortable and  
25 It should be evident from a reading of our Brief  
26 remain seated. It may be a long stand.

27 that we view Bill 163 as a totally inadequate answer to the  
28 MR. BURT: I will introduce myself first, if I  
29 problems inherent in our present system of private sickness  
30 am permitted. I am George Burt, the Canadian Director of  
31 insurance and our present methods of organizing, financing and  
32 UAW, United Automobile Workers of America and to assist me, and  
33 delivering health care services. We have dealt with this sub-  
34 to assist you, I hope, in our presentation I have on my right  
35 ject on the basis of your terms of reference but we would prefer  
36 Dr. Ted Goldberg, and on my left Mr. John Sparks, both of whom  
37 and our policy is, a universal plan, paid for in full through an  
38 are health care consultants with the International Union of the





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1 UAW and attached to our Social Security Department.

2 THE CHAIRMAN: Do you wish to proceed?

3 MR. BURT: We appreciate the opportunity to  
4 appear before you on a subject which has been of vital concern  
5 to organized labour in Canada for many, many years. The role  
6 established for the government of Ontario in the field of  
7 prepaid medical care insurance will directly influence the  
8 activities and attitudes of other provincial governments in this  
9 field. Indeed, what is involved here is the need to define the  
10 proper level and extent of the responsibilities of government  
11 over the whole field of health services and insurance. Thus,  
12 we hope you will seek in your studies and deliberations to face  
13 up to the full implications for the people of this province of  
14 the government functions, financial responsibilities and relation-  
15 ships which are inherent in Bill 163. In these introductory  
16 remarks, I will make reference to certain objections we have to  
17 the role which would be assigned to government in these areas,  
18 under this Bill.

19 It should be evident from a reading of our Brief  
20 that we view Bill 163 as a totally inadequate answer to the  
21 problems inherent in our present system of private sickness  
22 insurance and our present methods of organizing, financing and  
23 delivering health care services. We have dealt with this sub-  
24 ject on the basis of your terms of reference but we would prefer  
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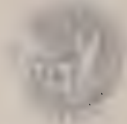
1 equitable system of taxation.

2 Bill 163 would, in effect, develop a system of  
3 "medical social assistance" to be made available to an unknown  
4 and changing proportion of the people of the province who are  
5 deemed, under some undefined test, to be "in needy circumstances".  
6 To speak bluntly, public funds would be used only to subsidize  
7 and not to purchase health services. And such subsidies would  
8 only be made available to that element of the self-supporting  
9 population who have been found to be financially incapable of  
10 purchasing private insurance at the present level of premium  
11 rates. This will do nothing to help families of modest income.

12 Looked at from another direction, Bill 163 would  
13 provide a form of bad debt insurance for physicians covering  
14 that segment of the population which we are assured is never  
15 denied medical care because of inability to pay for it.

16 Bill 163 clearly reflects the commercial principles  
17 and philosophy of those who would have us accept the proposition  
18 that health care is a marketable commodity, whose purchase is  
19 aided by the mechanism of prepayment. Public support they would  
20 only permit to be applied to the purchase of private insurance  
21 by those in "needy circumstances".

22 We recognize that voluntary medical care insur-  
23 ance has played an important part in assisting many Canadians  
24 to finance, in some degree, the cost of physicians' services.  
25 As a matter of fact, organized labour has played an important



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1 part in efforts to improve the coverage and benefit provisions  
2 of these plans. Indeed, the collective bargaining mechanism and  
3 the enrolling of large groups of workers has materially helped  
4 the plans to remain in business. But, organized labour in  
5 many public pronouncements, including its submissions to the  
6 Saskatchewan Advisory Planning Committee on Medical Care and  
7 to the Royal Commission on Health Services, has in no uncertain  
8 terms expressed its belief in the need for a broad health care  
9 program. Such a plan would be universal in coverage; compre-  
10 hensive in scope; and coordinated with means to improve and  
11 extend community health services, and to achieve a better  
12 supply and distribution of the health personnel and technical  
13 resources required to deliver the high potential of medical  
14 science. The public program we support would be financed under  
15 an equitable system of taxation and operated under the auspices  
16 of a public authority.

17 We recognize the potential benefits to be  
18 derived from the proposal to eliminate barriers of age, waiting  
19 periods and pre-existing conditions as applied to membership.  
20 We fully agree with the position that a proper system of prepaid  
21 health care must be designed to meet the health needs of the  
22 public, without these or other limitations designed to protect  
23 the insurance carriers. The Bill, however, completely ignores  
24 other elements in private insurance which effectively restrict  
25 the ability of certain groups to obtain protection. We refer here



part in efforts to improve the coverage and benefit provisions of these plans. Indeed, the collective bargaining mechanism and the enrolling of large groups of workers has materially helped the plans to remain in business. But, organized labor in many public personnel, including the submissions to the Saskatchewan Advisory Planning Committee on Medical Care and to the Royal Commission on Health Services, has an uncertainty terms expressed its belief in the need for a broad health care program. Such a plan would be universal in coverage, comprehensive in scope; and coordinated with efforts to improve and extend community health services, and to attract a better supply and distribution of the health personnel and technical resources required to deliver the high potential of medical science. The public program we support would be based upon an equitable system of taxation and operated under the auspices of a public authority.

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1 to factors which affect premium rates and which are completely  
2 beyond the control of the consumer -- such as the prices to be  
3 paid for medical services, assessment policies to be applied in  
4 claims administration, and other areas of policy application  
5 which can increase costs without a corresponding increase in  
6 services to the consumer.

7 Under the proposed program, the extent of prov-  
8 incial subsidy would be limited, however, by reference to the  
9 financial status of the persons seeking enrollment. This  
10 limitation of the public role to subsidization of voluntary  
11 insurance will not assist the great majority of self-supporting  
12 families who remain above the "needy" category. Moreover, the  
13 large-scale application of a means test is repugnant to us as  
14 to most citizens. It deeply offends our sense of self-respect  
15 and our idea of privacy of person. The advocates of restricting  
16 public subsidy only to those in "needy circumstances" have, it  
17 should be mentioned, developed a curious defense of the means  
18 test principle. They argue that all citizens face a means test  
19 under our income tax system. This is a specious line of  
20 argument.

21 Our income tax system is a method to achieve a  
22 contribution from all citizens to meet the costs of public  
23 services. Under a progressive system of taxation, personal  
24 deductions are purely an administrative device to establish  
25 the level and rate at which income is taxable, not to establish



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1 a person's entitlement to benefits.

2 In addition, there are serious technical difficult-  
3 ies and implications involved in administering a large scale  
4 means or needs test program. A person's economic situation,  
5 as well as his needs, are not stable from year to year or even  
6 from month to month. At any time, an individual's means must  
7 be related to his needs if the test is to distinguish, in an  
8 equitable manner, over a reasonably short period of time, between  
9 those who are or are not deemed able to meet their medical  
10 insurance costs without assistance. A costly system of  
11 verification and reverification must be established if uniform-  
12 ity and equity of application is to be achieved.

13 We have made no estimate of the number of persons  
14 who might fall under such a means test system. As mentioned,  
15 such a system would not, of course, provide any assistance  
16 to those who now have some form of insurance, however limited.  
17 And if the means or needs test is a severe one, then few will  
18 be assisted among the remaining 40% of the population of  
19 Ontario who now have no medical care insurance whatsoever.  
20 Furthermore, if a liberal definition of persons "in needy  
21 circumstances" is used, it will increase public subsidies to the  
22 point where only a universal tax supported system can be  
23 justified. Such a system would, of course, if based on the  
24 ability to pay principle, establish a stable and flexible  
25 financial base, applicable to all, on an equitable basis.



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23 ability to pay principle, establish a stable and flexible

24 financial base, applicable to all, on an equitable basis.





1 We have mentioned in our Brief a number of  
2 technical limitations and inadequacies of the Bill, some of  
3 which have been noted in our summary. I would stress four  
4 points here:

5 (1) The Bill provides the option to the  
6 individual of purchasing either limited in-hospital medical care  
7 coverage under Schedule B, or comprehensive coverage under  
8 Schedule A. Limited coverage, at lower premium levels, will  
9 tend to force persons of limited means to purchase this form  
10 of insurance. This option is based on the assumption that  
11 persons should be free to choose the coverage suited to their  
12 individual requirements. In fact, this choice really rests on  
13 the person's ability to pay. Moreover, illness costs and  
14 health care requirements are uneven and unpredictable for the  
15 individual. The average person is unable to distinguish and  
16 discriminate in regard to the health services he may require,  
17 and should therefore prepay. Such limited medical insurance  
18 will also encourage some to seek hospitalization in order to  
19 obtain insured care, and this will foster the uneconomic use  
20 of hospital facilities.

21 (2) It is not clear from reading the Bill,  
22 whether it contemplates that insured services will be provided  
23 on a basis whereby the patient will not be liable for additional  
24 charges in respect of covered services. This question of  
25 extra-billing has plagued the members of both non-profit service



which have been noted in our summary. I would stress four points here:

(1) The Bill provides the option to the individual of purchasing coverage under Schedule A, limited coverage, at lower premium levels, will tend to force persons of limited means to purchase this form of insurance. This option is based on the assumption that persons should be free to choose the coverage suited to their individual requirements. In fact, this choice really rests on the person's ability to pay. Moreover, illness costs and health care requirements are uneven and unpredictable for the individual. The average person is unable to diversify and discriminate in regard to the health services he may need, and should therefore prepay. Such limited medical insurance will also encourage some to seek hospitalization in order to obtain insured care, and this will foster the uneconomic use

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1 plans and commercial, indemnity or reimbursement plans.  
2 Certainly for the group in the population for which subsidized  
3 coverage is to be made available, there should be no question  
4 that that patient should receive full-service protection. We  
5 submit, further, that all members of voluntary plans under the  
6 proposed program must have this guarantee, if the program is  
7 to provide adequate family security against medical care  
8 costs. Any other approach assumes that a patient is in a  
9 position, or is inclined, to argue about charges with his  
10 physician at the time when his services are needed.

11 (3) We are also concerned that the competition  
12 between carriers under the proposed program will not operate  
13 to the benefit of the general public. It seems quite possible  
14 that because of the use of experience rating by the commercial  
15 carriers, these carriers may tend to gain a competitive  
16 advantage over carriers using community rating. This would tend  
17 to concentrate the poor-risk groups in certain carriers and  
18 thus force up premium rates. This then establishes a vicious  
19 circle, whereby premium rates continue to rise and the better  
20 risks are concentrated in commercial carriers to the detriment  
21 of the poorer-risk groups in community rated plans. A substantial  
22 government subsidy paid on behalf of all members of voluntary  
23 plans under this program would help, of course, to level out prem-  
24 ium costs and permit a much larger enrollment.

25 (4) The lack of any provision in the Bill for







1 effective public control is another matter of serious concern.  
2 The only authority given to the Superintendent of Insurance  
3 is the provision requiring his consent to an increase in  
4 maximum subscription rates. To place the program wholly under  
5 the control of private carriers is unjustified and unacceptable.  
6 Insurance companies are in the business of sickness insurance  
7 for profit. The non-profit plans are under the effective  
8 control of the medical profession. And organized medicine wishes  
9 to retain this form of medical syndicalism. I think it is  
10 illuminating, in this regard, to quote, in part, the President  
11 of the Canadian Medical Association, Dr. W.W. Wigle, in the  
12 September 8, 1962 issue of the Canadian Medical Association  
13 Journal.

14 "... the prepayment of medical care in all  
15 "its phases -- the collection of the funds, the  
16 "administration and the payment for the services  
17 "--must be more diligently studied and controlled  
18 "by the profession or it will be done by  
19 "someone else. No one else should be acceptable  
20 "to us . . . "

21 Given present trend in the costs of patient care,  
22 and a liberal means test, we can expect that the government  
23 subsidies proposed will steadily increase in size. Now public  
24 control and scrutiny over the expenditure of public funds is an  
25 essential element of our democratic system of government. All



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1 elements affecting premium costs and thus the level of public  
2 subsidies should be matters in which the public interest is  
3 preserved. I refer here to such matters as the level of, and  
4 changes in, the payments to be made for insured services;  
5 the policies and procedures applied in claims administration;  
6 expenditures on administration; and other internal aspects  
7 of the activities of the carriers which have a close bearing  
8 on costs and premium rates.

9 Medical care services are "clothed with a public  
10 interest" and are not a private commodity where prices are  
11 determined in the "open market". The prices charged for medical  
12 services and the financial operations applied under prepayment  
13 should not be under the sole control of the providers of  
14 service or of the insurance carriers. We have suggested in  
15 this regard the development of a Public Review Commission to  
16 represent the public interest in any program which you may recom-  
17 mend involving public funds.

18 May I now read to you the fifteen points which  
19 summarize the main conclusions and recommendations contained  
20 in our Brief.

21 And this is the end, at this time, of our  
22 observations in relation to our brief. I have read your  
23 Chairman's statement here and I might say, for the benefit of  
24 your Committee and to assist you as much as we can, my colleagues  
25 here are in a much better position to answer technical questions



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...





VERBATIM REPORTING  
SERVICE  
TORONTO, ONTARIO

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1 than I am. This is their work. They are trained in this  
2 line of work and, therefore, I would suggest that if you do  
3 direct questions to me as spokesman, I can refer to one of  
4 my colleagues to answer the question.

5 THE CHAIRMAN: Yes. Thank you. Quite a  
6 number of the members of the Enquiry have indicated a desire  
7 to ask some questions here. Would you start?

8 MISS CARPENTER: It was very interesting, and  
9 the first question I would like to ask you is in relation  
10 to the first recommendation. You recommend the whole range  
11 of services be included, and on page 6 of your presentation  
12 this is enlarged to include dentist, nurse, therapist,  
13 pharmacist, social worker, dietitian, et cetera. I wonder  
14 if you have thought that these services should be included  
15 under Bill 163 or how do you propose -- are they appropriate  
16 to this particular legislation?

17 MR. BURT: We are now dealing with 8, No. 8  
18 on page 6?

19 MISS CARPENTER: Yes, paragraph 8 on page 6  
20 and recommendation one on your first page.

21 MR. BURT: We are dealing with the dentists?

22 MISS CARPENTER: The last sentence on paragraph  
23 8 spells out the numbers of people that you think should be  
24 included as persons who contribute to health service. My  
25 question was do you recommend that all these services be included



1 than I am. This is their work. They are trained in this  
2 line of work and, therefore, I would suggest that if you do  
3 direct questions to me as a spokesman, I can refer to one of  
4 my colleagues to answer the question.

5 THE CHAIRMAN: Yes. Thank you. Quite a  
6 number of the members of the Board have indicated a desire  
7 to ask some questions here. Would you start?

8 MISS CARPENTER: It was very interesting, and  
9 the first question I would like to ask you is in relation  
10 to the first recommendation. You recommend the whole range  
11 of services be included, and on page 2 of your presentation  
12 this is enlarged to include dentist, nurse, therapist,  
13 pharmacist, social worker, dietitian, et cetera. I wonder  
14 if you have thought that these services should be included  
15 under Bill 103 or how do you propose -- are they appropriate  
16 to this particular legislation?

17 MR. BURR: We are now dealing with 8, No. 8

18 on page 6?

19 MISS CARPENTER: Yes, paragraph 8 on page 6

20 and recommendation one on your first page.

21 MR. BURR: We are dealing with the dentist?

22 MISS CARPENTER: The last sentence on paragraph





1 in Bill 163?

2 MR. BURT: Yes, we do.

3 MISS CARPENTER: You think this is the appropriate  
4 Bill? We had reference to the present Hospital Services  
5 Act and wondered whether you feel some of these services  
6 were not more appropriate under hospital services or whether  
7 you believe they belong under Bill 163?

8 MR. BURT: We would be opposed to separating  
9 the services in this field. We would much prefer to having  
10 them under one piece of legislation, if that could be possible.

11 MISS CARPENTER: On the next page, in paragraph  
12 10 you speak of integrating the whole range of preventive  
13 services into a general system of medical care. I wondered  
14 in relation to that, do you mean then eventually all these  
15 services should come under, for instance, the Public Health  
16 Department?

17 MR. BURT: We would prefer that.

18 MISS CARPENTER: You would prefer that rather  
19 than have them separated under different kinds of legislation?

20 MR. BURT: Yes.

21 MISS CARPENTER: In relation to No. 5 on page  
22 9, at the end of paragraph 13 you are speaking of the fee for  
23 service method of payment and in the second to last sentence  
24 say:

25 "Freezing the present patterns of care will



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MR. BURT: Yes, we do.

MISS CARPENTER: You think that is the appropriate

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Act and wondered whether you feel some of these services

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in relation to that, do you mean then eventually all these

services should come under, for instance, the Public Health

Department?

MR. BURT: We would prefer that.

MISS CARPENTER: You would prefer that rather

than have them separated under different kinds of legislation?

MISS CARPENTER: In relation to No. 2 on page

9, at the end of paragraph 13 you are speaking of the fee for

service method of payment and in the second to last sentence

"freeing the present patterns of care will





1 perpetuate present patterns of utilization of hospital services  
2 and medical care."

3 In what ways do you think that this is not  
4 advantageous; that this present pattern is not advantageous  
5 to the citizens of Ontario?

6 MR. GOLDBERG: Mr. Chairman, the pattern of  
7 medical care, the pattern of practice as established seems  
8 to induce very high hospital utilization which is, as you know,  
9 probably the most expensive facility through which we can  
10 provide medical care.

11 Now it seems to us, from studies that have been  
12 conducted very generally, that different patterns of medical  
13 care leading to more attention being provided in other than  
14 hospital facilities is necessary and apparently if this is  
15 done, and maintained, and increase the quality of care given  
16 to the patient, it seems to us that if this is related to the  
17 type of payment made to the physician, if this is related to  
18 the type of program established, then we should certainly take  
19 a very close look at the kind of program we establish, whether  
20 it will induce unnecessary hospital utilization.

21 We think there is evidence to lead us to believe  
22 that the type of program is important in determining the type  
23 of hospital utilization. If we can achieve a program that  
24 will reduce unnecessary hospital utilization, we think this  
25 would be a good thing.

2 And medical care."

3 In what ways do you think that this is not

4 advantageous; that this present pattern is not advantageous

5 to the citizens of Ontario?

6 MR. GOLDBERG: Mr. Chairman, the pattern of

7 medical care, the pattern of practice as established seems

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11 conducted very generally, that different patterns of medical

12 care leading to more attention being provided in other than

13 hospital facilities is necessary and apparently if this is

14 done, and maintained, and increase the quality of care given

15 to the patient, it seems to me that if this is related to the

16 it will induce unnecessary hospital utilization.

17 We think there is evidence to lead us to believe

18 that the type of program is important in determining the type

19 of hospital utilization. If we can achieve a program that

20 would be a good thing.





1 MISS CARPENTER: You think the fee for service  
2 type of payment contributes to over-utilization of hospitals?

3 MR. GOLDBERG: We think there is some evidence  
4 to support that, yes.

5 MISS CARPENTER: Turning to the top of page  
6 2, in your discussion in the introduction of this brief, you  
7 are here suggesting that Government contribution of at least  
8 50% of premiums for each subscriber be made in addition to the  
9 full payment. I gather then you mean regardless of the  
10 individual's ability to pay?

11 MR. BURT: Your question was our proposal was  
12 in accordance with the ability to pay?

13 MISS CARPENTER: It is regardless of the ability  
14 to pay. In this first sentence you feel everybody should have  
15 this subsidy?

16 MR. BURT: Yes, of course. Also in my opening  
17 statement the sort of legislation we would prefer would deal  
18 with this in a different manner because it would mean that  
19 you would have universal coverage, you see, paid for by an  
20 equitable system of taxation, but we tried to deal with this  
21 whole program in the light of Bill 163 also, and we say that  
22 if you are going to hang on to this Bill 163, or any portion of  
23 it, then in this area you should -- the subscriber and his  
24 payment should be based on his need rather than on his ability  
25 to pay.



MISS CARPENTHER: You think the fee for service

to support that, yes.

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50% of premiums for each subscriber be made in addition to the

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with this in a different manner because it would mean that

you would have universal coverage, you see, paid for by an

equitable system of taxation, but we tried to deal with this

whole program in the light of Bill 103 also, and we say that

if you are going to hang on to this Bill 103, or any portion of

it, then in this area you should -- the subscriber and his

payment should be based on his need rather than on his ability





1                   MISS CARPENTER: You go on on the next page,  
2 page 3 to say that no fee be required from persons who are  
3 laid off. I wonder how you suggest this be administered? Laid  
4 off for a length of time, or laid off for any length of time  
5 at all?

6                   MR. BURT: Well we don't know how you are  
7 going to determine a need in this area, in any case, and one  
8 of the tests is a person would be without income. Now then  
9 how you would put a yardstick on whether or not he is in the  
10 need category would be a very difficult thing to apply because  
11 a person can be laid off for a month and be single, and a person  
12 could be laid off for a month and have ten kids and he is  
13 in an entirely different circumstance so that we really kept  
14 away from applying a yardstick, but we are bothered with this  
15 suggestion of a yardstick according to need and it is really  
16 very difficult, if we hang on to this one, to apply any kind  
17 of a yardstick we think, but we think one of the most acceptable  
18 tests, or probably one of the acceptable tests would be a  
19 person who is unemployed.

20                   MISS CARPENTER: I see, and have to report  
21 their unemployment immediately then. If they are out for  
22 any period of time you think they would ---

23                   MR. BURT: Be eligible for unemployment insurance,  
24 I suppose would be a test. That would probably be one of  
25 the easiest to determine.



MISS CARPENTIER: You go on on the next page.

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laid off. I wonder how you suggest this be administered? Laid

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their unemployment immediately then. If they are out for

any period of time you think they would ---

MR. BURT: Be eligible for unemployment insurance?

I suppose would be a test. That would probably be one of

the easiest to determine.



1 MISS CARPENTER: I think that is all for now,  
2 thank you.

3 THE CHAIRMAN: Mr. Burt, there is one question  
4 that Miss Carpenter asked you there that I am not quite clear  
5 on as to your answer, No. 7 on page 2 where you say the  
6 Government contribution of at least 50% of the premium for  
7 each subscriber in addition to the full payment for those  
8 "in needy circumstances" and those qualifying by being  
9 recipients of benefits under an established list of welfare

10 Acts. I find it a little difficult to reconcile this with  
11 what you said in your opening statement which was to the  
12 effect that if you couldn't have an entirely socialized plan, as  
13 I recall it, then you think those who could pay should pay.  
14 Am I right that these things don't quite jibe?

15 MR. BURT: Maybe Dr. Goldberg could answer that  
16 a little more fully. I am sorry if I confused you.

17 DR. GOLDBERG: Our basic proposal is that  
18 we advocate and, strongly advocate, a universal system paid  
19 out of general revenue. This will solve the problem if  
20 everyone is covered generally and it is paid out of taxation.  
21 However, within the terms of Bill 163, if this is to be made  
22 workable at all, be made significant to any portion of the  
23 people it obviously needs a large injection of public funds  
24 even within the confines of Bill 163.

25 We are saying if this is going to be made meaningful





THE CHAIRMAN: Mr. Burns, there is one question

that Miss Carpenter asked you there that I am not quite clear

on as to your answer, No. 7 on page 2 where you say the

Government contribution of at least 50% of the premium for

each subscriber in addition to the full payment for those

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what you said in your opening statement which was to the

effect that the Government should not be responsible for

I recall it, then you think those who could pay should pay.

Am I right that these things don't quite fit?

MR. BURNS: Maybe Mr. Goldberg could answer that

a little more fully. I am sorry if I confused you.

DR. GOLDBERG: Our basic proposal is that

we advocate and, strongly advocate, a universal system paid

out of general revenue. This will solve the problem of

the Government's financial position and will also solve the

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even within the confines of Bill 105.

We are saying if this is going to be made meaningful



1 to any people of the province even within the confines of  
2 Bill 163 if you retain it there should be at least an  
3 injection of 50% of public revenue into the plan, to provide  
4 at least that much assistance to people paying the premiums.

5 THE CHAIRMAN: Without regard to their ability  
6 to pay?

7 DR. GOLDBERG: Yes.

8 THE CHAIRMAN: Thank you. Dr. Butt?

9 DR. BUTT: Thank you. It is a very interesting  
10 brief. Coming back to this very specific point: you state  
11 50% of the premiums for each subscriber. Do you feel that  
12 the needy should pay this 50%?

13 DR. GOLDBERG: It says further 100%.

14 DR. BUTT: You feel this should be 100% and  
15 you want 50% to be paid anyway whether they need it or not,  
16 a person who is financially able to take care of all his  
17 premium?

18 DR. GOLDBERG: Dr. Butt, our basis proposal,  
19 our proposition to you is one . . .

20 DR. BUTT: May I . . .

21 DR. GOLDBERG: I am trying to answer the question.

22 DR. BUTT: I asked you a specific point.

23 DR. GOLDBERG: If you retain Bill 163, if you  
24 retain these things that we don't advocate, that we oppose,  
25 if you in your wisdom retain this we say yes, 50% to everyone on



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Bill 103 if you retain it there should be at least an

injection of 50% of public revenue into the plan, to provide

at least that much assistance to people paying the premiums.

DR. GOLDBERG: I think you are right.

DR. BUTT:

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DR. BUTT: Now I . . .

DR. GOLDBERG: I am trying to answer the question.

DR. BUTT: I asked you a specific point.

DR. GOLDBERG: If you retain Bill 103, if you

retain these things that we don't advocate, that we oppose,

if you in your wisdom retain this we say yes, 50% to everyone





1 their premiums should be paid.

2 DR. BUTT: Would you define what you mean by  
3 necessary medical care?

4 DR. GOLBERG: Anything that medical science  
5 has learned is required to improve and maintain a person in  
6 the fullest state of health possible.

7 DR. BUTT: What do you mean by maintenance of  
8 quality care then?

9 DR. GOLDBERG: Sir, in this area we are  
10 inclined to judge by people in the medical profession who have  
11 tried to determine standards of quality of care.

12 DR. BUTT: In what ways are these determined?

13 DR. GOLDBERG: Well, I suppose a good deal by  
14 medical judgment, a good deal by the techniques that the  
15 science of medicine uses in establishing their profession.

16 DR. BUTT: Are any of these established by  
17 Acts?

18 DR. GOLDBERG: By Acts?

19 DR. BUTT: Disciplinary Acts?

20 DR. GOLDBERG: I suppose there are standards  
21 established by Acts regarding hospitalization, hospital charges,  
22 legislation and so on, yes.

23 DR. BUTT: Do you feel there is any incongruity  
24 between your statements one and three? You say no standards  
25 for determination and maintenance of quality care are established

1 their premiums should be paid.

2 DR. BUTT: Would you define what you mean by

3 has learned its reputation for hygiene and sanitation in

4 DR. BUTT: What is your mean by maintenance of

5 quality care there?

6 DR. GOLDBERG: Sir, in the area we are

7 inclined to judge by people in the medical profession who have

8 tried to determine standards of quality of care.

9 DR. BUTT: In what ways are these determined?

10 DR. GOLDBERG: Well, I suppose a good deal by

11 medical judgment, a good deal by the statistics that the

12 science of medicine uses to establish their position.

13 DR. BUTT: Are any of these established by

14 DR. GOLDBERG: By Act?

15 DR. BUTT: Discretionary Act?

16 DR. GOLDBERG: I suppose there are standards

17 legislation and so on, yes.

18 DR. BUTT: Do you feel there is any inconsistency

19 between your statements one and three? You say no standards

20 for determination and maintenance of quality care are established



1 in the Act, then you recommend legislation to encompass the  
2 whole range of services which takes in groups which have  
3 no rules or no disciplinary body. Are these not incompatible?

4 DR. GOLBERG: I am sorry, I don't understand  
5 the question. Would you repeat it?

6 DR. BUTT: You wish to be included in the Bill  
7 all types of care, some of which you went into very long  
8 discussion as to what you feel should be adequate. Some of  
9 these are not under any particular Act by which they could be  
10 controlled or disciplined. How in this manner do you feel you  
11 are enhancing the quality of medical care which is what you  
12 desire in No. 3?

13 DR. GOLBERG: Are you . . .

14 DR. BUTT: If these groups couldn't be controlled.

15 DR. GOLDBERG: Which groups?

16 DR. BUTT: You mentioned . . .

17 DR. GOLDBERG: Are these nurses, physiotherapists?

18 DR. BUTT: Yes.

19 DR. GOLDBERG: Are they not licensed?

20 DR. BUTT: Yes. You want these controlled  
21 under this Act. This is what you are trying to say?

22 DR. GOLDBERG: We want standards established.

23 DR. BUTT: That is all.

24 MR. SPARKS: Mr. Chairman, may I be permitted  
25 to supplement Dr. Goldberg. I don't think one should consider





1 in the Act, then you recommend legislation to encompass the

2 whole range of services which takes in groups which have

3 no rules or no disciplinary body. Are these not incompatible?

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5 the question. Would you repeat it?

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7 all types of care, some of which you want into very long

8 discussion as to what you feel should be adequate. Some of

9 these are not under any particular Act by which they could be

10 controlled or regulated. You are talking about the

11 various types of care which are not under any Act at present.

12 groups in the Bill

13 DR. GOLDBERG: Are you . . .

14 DR. BUTT: If these groups couldn't be controlled

15 DR. GOLDBERG: Which groups?

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17 the various types of care which are not under any Act at present.

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19 DR. GOLDBERG: Are they not licensed?

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21 under this Act. This is what you are trying to say?

22 DR. GOLDBERG: We want standards established.

23 DR. BUTT: That is all.

24 MR. SPARKS: Mr. Chairman, may I be permitted

25 to supplement Dr. Goldberg. I don't think one should consider



1 that all implications of quality of care be blanketed by  
2 legislation. There is a wide variety of different methods  
3 which professional bodies have in becoming involved in  
4 matters relating to the quality of patient care. In addition  
5 there are certain public standards established through  
6 legislation giving this authority to certain professional  
7 groups. By and large the basic control of quality care is  
8 the individual physician. What we are attempting to say here  
9 is that in the type of program we envisage we would like to  
10 see the structure of the program, the manner in which the  
11 services are organized do everything to enhance the professional  
12 ability and improve and extend quality of care to more  
13 people.

14 There is no implication in the brief that in  
15 any way you legislate by some edict to the extent to which  
16 any one of the professions in its day to day practice apply  
17 profession skill. I think you have to distinguish here between  
18 this and the type of system we would like which would be a  
19 large-scale organization, multiplicity of services and  
20 multiplicity of skills permitting each of the professions to  
21 better operate.

22 DR. BUTT: Could you explain exactly what  
23 you mean by No. 3, the third recommendation? You don't mean  
24 to have it legislated in the Act in some manner. Just for  
25 my own clarification what are you referring to if you don't



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2 legislation. There is a wide variety of different methods  
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15 any way you legislate by some edit to the extent to which  
16 any one of the professions in its day to day practice apply  
17 profession skill. I think you have to distinguish here between  
18 the fact that the law is a guide to what you should do  
19 large-scale organization, multiplicity of services and  
20 multiplicity of skills permitting each of the professions to  
21 better operate.

22 DR. BURT: Could you explain exactly what  
23 you mean by No. 3, the third recommendation? You don't mean  
24 to have it legislated in the Act in some manner. Just for  
25 my own clarification what are you referring to if you don't





1 feel this is true. What do you mean exactly by it?

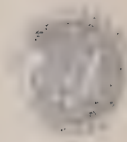
2 MR. SPARKS: I think, sir, and again this is  
3 speculation on the manner in which this would be applied in  
4 the Act, there could be provision made in the Act, for example,  
5 for new methods of organization of certain aspects of medical  
6 service. I am referring particularly to the relationship between  
7 general practitioners and specialists. Provision could be  
8 given to provide better distribution of specialists in the  
9 province, some incentive to promote specialists' services to  
10 be re-organized. This is one example of the sort of extension  
11 in the organizational area which would provide the physician  
12 with better access to specialist care outside large urban  
13 areas. Similarly the Act could anticipate various forms of  
14 organization of practice to be established in the Act which  
15 in itself could lead to improved quality of care. I don't  
16 think that a general statement under 3 should be used to draw  
17 any reference to the fact that as I said one can legislate  
18 high quality care.

19 One can encourage. One can establish the  
20 structure in which it can be improved and extended.

21 DR. BUTT: Specifically how would you suggest  
22 it be put into the Act to do this sort of thing?

23 MR. SPARKS: Sir, I gave you one example.

24 DR. BUTT: You gave me an example of redistribut-  
25 ing specialists. I believe that is what you tried to say.



1 feel this is true. What do you mean exactly by it?

2 MR. SPARKS: I think, sir, and again this is

3 speculation on the manner in which this would be applied in  
4 the Act, there could be provision made in the Act, for example,

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13 areas. Similarly the Act could anticipate various forms of

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16 One can encourage it. One can establish the

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18 DR. BUTT: Specifically how would you suggest

19 is be put into the Act to do this sort of thing?

20 MR. SPARKS: Sir, I gave you one example.

21 DR. BUTT: You gave me an example of restriction.



1 MR. SPARKS: That is correct.

2 DR. BUTT: In what way could this be done?

3 MR. SPARKS: Again I think it is probably asking  
4 too much for us to go into the specific details of how this  
5 would be implemented in the Act. We are prepared to provide  
6 a written submission on it. In general terms what would be  
7 involved is by undertaking arrangements with specialist groups  
8 within the profession to arrange for a redistribution so to  
9 speak of specialist services at the regional level so that these  
10 services on referral would be made more accessible to the  
11 local general practitioner in a way they are not made now.

12 DR. BUTT: You feel this should be put into  
13 the Act, just to clarify my thinking?

14 MR. SPARKS: Yes I tried to get that, what we  
15 are attempting in No. 3 is not to define exactly how this  
16 arrangement should be made, but that the Act should be broadened  
17 so that such arrangements could be made in its administration.

18 MR. WHITNEY: If it were made under Regulation  
19 3 would you be satisfied with that? Isn't it really a  
20 regulatory measure you are discussing?

21 MR. SPARKS: It isn't only regulatory. I  
22 think there is a fundamental difference between what is in an  
23 Act or regulation, a fundamental difference between a directive,  
24 a regulatory directive as to how services should be organized  
25 and an incentive to extend new forms of re-organization of medical



MR. SPARKS: That is correct.

MR. BURT: To what way could this be done?

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too much for us to go into the specific details of how this

would be implemented in the Act. We are prepared to provide

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MR. SPARKS: Yes I tried to get that, that we

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MR. WHITNEY: It is more wide and far-reaching.

3 would you be satisfied with that? Isn't it really a

regulatory measure you are discussing?

MR. SPARKS: It isn't only regulatory. I

think there is a fundamental difference between what is in an

Act on regulation, a fundamental difference between a directive



1 services in manners which we feel would improve the quality  
2 of care.

3 MR. WHITNEY: It sound more like a regulation  
4 to me.

5 DR. GOLDBERG: Another problem, Mr. Whitney . . .

6 MR. WHITNEY: I am sorry, Mr. Chairman. I  
7 hope I haven't interfered.

8 THE CHAIRMAN: We will give you a little leeway,  
9 but don't do it again.

10 DR. GOLDBERG: Mr. Whitney specific regulations  
11 are rather hard to comment on. When it is provided in the  
12 legislation then it can be subjected to public scrutiny and  
13 discussion. You can discuss whether the Act is adequate or  
14 inadequate. When it is left to regulation you can't discuss  
15 it since it is not known. We think this is so important it  
16 should be included in the legislation so it can be subjected  
17 to discussion and scrutiny.

18 DR. BUTT: To continue, on page 11 you refer  
19 to voluntary health plan services, medical care services,  
20 physician-sponsored service-type plans, commercial insurance  
21 and so on. I don't wish to go into this in detail. There is  
22 a number of different terms used, and then statistics brought  
23 in and they are used, they are distributed to different phases  
24 of the same thing. I think the terms and statistics apply  
25 to different little parts. I find it rather difficult to bring



services in manners which we feel would improve the quality

MR. WHITNEY: It sound more like a negotiation

MR. GOLDBERG: Another problem, Mr. Whitney.

MR. WHITNEY: I am sorry, Mr. Chairman. I

hope I haven't interfered.

THE CHAIRMAN: We will give you a little leeway,

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1 out what 23% and 12.9% mean with regard to these terms. To  
2 be more specific, I feel rather than going through all this  
3 at this point, I would be most interested if you would file  
4 the source of material. I think this would be of great value  
5 to the Enquiry. I don't wish to labour this thing. I think  
6 we have been on too long.

7           The other thing I was wondering is, as we went  
8 through your brief there are many questions you ask. While  
9 I don't mean to be facetious, we would really like to know  
10 some of the answers, the specific answers. I tried to extract  
11 a specific answer on one recommendation. I would be most  
12 interested in receiving this and then I think we could go on.

13           MR. BURT: Which specific recommendation?

14           DR. BUTT: You ask us a lot of questions, how  
15 would you determine needs tests, unemployment insurance, how  
16 we should determine that. Many of the questions you ask, I  
17 believe in asking you may have some answers and we would be  
18 most interested in having them. If you have the source of  
19 material on which these are based I would be interested in  
20 receiving it.

21           MR. BURT: We ask these questions in the light  
22 of what is contained in the Bill itself. We don't know what  
23 the Bill means. That is your Terms of Reference. It is  
24 difficult for us to read the Bill.---

25           DR. BUTT: You stated you have certain studies and



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1 sources of material. We would be interested in having these.

2 THE CHAIRMAN: You understand Dr. Butt is  
3 asking wherever you have specific information on the statements  
4 you have made in a general way we would like to have the  
5 specific material from which it is drawn, from studies. We  
6 would be prepared to study that in our discussions.

7 MR. BURT: We made notes on that. We will do  
8 that.

9 DR. GALLOWAY: Mr. Chairman, on the same matter  
10 could I ask one question. Mr. Butt, in paragraph 20, I suspect  
11 without knowing, this is from a thesis of Dr. Ted Goldberg.  
12 If this is true I wonder if he, from his memory, having indicated  
13 the percentage of costs that are paid by present insurance  
14 plans for what you have considered medical health care, drugs,  
15 prescriptions et cetera, could you from your memory, Ted, tell  
16 us the percentage of professional, that is medical fees or  
17 costs that were paid?

18 DR. GOLDBERG: I don't think I could use my  
19 memory, but I think I have some notes. Dr. Galloway, Mr.  
20 Chairman, if I understand the question correctly, physician  
21 charges alone, the service plans have 58.7% of physicians'  
22 charges alone and indemnity plans paid 30.4% of physician  
23 charges alone.

24 DR. GALLOWAY: Thank you.

25 THE CHAIRMAN: Does that answer your question?



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2 THE CHAIRMAN: You understand Dr. Burt is

3 asking wherever you have specific information on the statements

4 you have made in a general way we would like to have the

5 specific material from which it is drawn, from studies, the

6 would be prepared to study that in our discussions.

7 MR. BURT: We have noted on them. We will do

8 DR. TALLEY: Mr. Chairman, on the same matter

9 could I ask one question. In fact, in answer to it, I suggest

10 without knowing this is from a thesis of Dr. Fred Goldberg.

11 If this is true I wonder if he, from his memory, being indicated

12 the percentage of costs that are paid by private insurance

13 plans for what you have considered medical needs, drugs,

14 prescriptions et cetera, could you from your memory, Fred, tell

15 us the percentage of professional, that is medical fees or

16 costs that were paid?

17 DR. GOLDBERG: I don't know. I could use my

18 memory, but I think I have seen notes. Dr. Talley, Mr.

19 Chairman, if I understand the question correctly, physician

20 charges alone, the services alone have 58.7% of physician

21 charges alone and indemnity plans paid 30.4% of physician

22 charges alone.



1 DR. GALLOWAY: Yes.

2 THE CHAIRMAN: Do you have any further  
3 questions? Mr. Coulter?

4 MR. COULTER: Thank you, Mr. Chairman. Gentle-  
5 men, I found your brief very interesting. I am going to come  
6 back to this 50 per cent. In our recommendations to the  
7 Minister, one of them will be what it is going to cost the  
8 Province. I was wondering in your studies, and I would imagine  
9 you made some studies on this, if we include your suggestion,  
10 if it was possible to include them and I think it is found  
11 on page 6, section 8, if it was possible to include these in  
12 the new Bill or if there was a new Bill or if this Bill is  
13 to be changed, would you have any idea what the cost might be,  
14 I mean the day costs, number of visits; have you done any  
15 work on that?

16 DR. GOLDBERG: Mr. Coulter, I think this is a  
17 challenge which I think we may be very interested in taking.  
18 If you would like us to submit an estimate of the cost of the  
19 proposal which we make we would be glad to work on it. We  
20 haven't yet determined the cost of such a plan other than the  
21 fact much of the cost is already being paid presently under  
22 one form or another, much of this is personal payment from one  
23 group or one person to another. There wouldn't be a great  
24 deal of additional cost in the program we are proposing.  
25 This is a reshifting of how costs are paid.



THE CHAIRMAN: Do you have any further

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1 We are asking really that the services be  
2 organized and costs met by a equitable method.

3 MR. COULTER: Maybe you didn't understand my  
4 question. Probably I didn't understand you. You are asking  
5 for Government contribution of 50% to all subscribers, and then  
6 you are asking for many things to be included in Bill 163, or  
7 that should be included. I was wondering if you calculated,  
8 if you had any study of what would be the cost. I think as  
9 you said the costs are now being paid and all you have to do  
10 is bring them together. I was wondering if you had done this.

11 On page 7 under No. 9 you would include prenatal  
12 and well-baby care. I understand that throughout the province,  
13 and first of all I had better tell you I am a layman on this  
14 Committee, I haven't really any special interest, only that  
15 of the public, but I understand that there are well-baby clinics  
16 pretty well distributed across the province. Could you tell  
17 me why you are advocating for an acceleration of this program,  
18 because my information is over the past year or two or three  
19 years that visits to well-baby clinics have declined.

20 DR. GOLDBERG: If this is so, Mr. Coulter,  
21 and I am not sure whether it is or not, I don't know the  
22 extent to which well-baby clinics are used. I would think if  
23 well-baby care is not being used the medical profession would,  
24 perhaps, be disturbed about this and suggest it be encouraged.  
25 We think this would be something for an organized plan to do, to

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question. Probably I didn't understand you. You are asking

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1 cover well-baby care.

2 MR. COULTER: My information, and I maybe should  
3 not disclose where it came from, but it is pretty wellfounded,  
4 I hope. I was wondering about this. It just bothered me that  
5 it should be on the decline. Somewhere here I believe I  
6 read you are recommending health examinations. Would this be  
7 on a yearly basis or two years or have you any ideas on this?

8 DR. GOLDBERG: There is quite a good deal  
9 of research now being done to determine precisely when periodic  
10 health examinations should be given. It seems to me just  
11 generally periodic health examinations are good. Precisely  
12 how often they should be taken probably depends a good deal  
13 on the individual. Some people probably should have periodic  
14 health examinations more often than others, diseases related  
15 to age.

16 When we are talking about well-baby care we  
17 are talking about periodic examinations. When we are talking  
18 about examinations for people over 40 we are talking about  
19 periodic health examinations. We think by excluding health  
20 examinations from the prepayment plan we discourage people from  
21 getting these examinations which would have a very beneficial  
22 effect on the state of health of the individual and society  
3 23 generally. I think more work is required as to how often  
24 these should be allowed. We are much opposed to excluding them  
25 from this legislation.





2 MT. COUNTRY: My information, and I maybe should  
3 not disclose where it came from, but it is pretty wellfounded,  
4 I hope. I was wondering about this. It just bothered me that  
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25 from this legislation.



1 MR. COULTER: This is the part that bothers  
2 me. If health examinations were included in whatever Bill  
3 was presented, final Bill was presented, the part that bothers  
4 me is the number of people of even the profession that might  
5 abuse this, I mean as far as public funds are concerned. This  
6 is one part that bothers me a little bit.

7 DR. GOLDBERG: In our experience we find rather  
8 than these services being abused that most of the physicians  
9 with whom we deal find that people don't come in for periodic  
10 health examinations frequently enough. They would like to  
11 encourage it rather than discourage it. I am not speaking on  
12 behalf of the physicians' medical association. I am speaking  
13 on behalf of physicians I have talked to. That seems to be  
14 their opinion.

15 MR. BURT: We have some difficulty in getting  
16 our people to go for an examination once a year. Our organiz-  
17 ation pays for it, and yet you still have to talk to your  
18 staff to get them to have this periodic examination. We think  
19 they are quite common. A lot of management people we deal  
/PE/rps 20 with -- a lot of them now in executive management, they  
21 volunteer to take a physicial examination once a year to sort  
22 of set an example also to junior people in executive positions  
23 and I think the annual examination is advocated -- at least I  
24 know by my doctor, and I do not know if it is generally true  
25 or not among the medical profession -- but at least once a year



MR. GOWDER: This is the part that bothers me. If health examinations were included in whatever Bill we passed, it would mean that the number of people of even the profession that might abuse this, I mean as far as public funds are concerned. This is one part that bothers me a little bit.

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MR. BURN: We have some difficulty in getting our people to go for an examination once a year. Our organization pays for it, and you still have to talk to your staff to get them to have this periodic examination. We think they are quite common. A lot of management people we deal with -- a lot of them now in executive management, they know by my doctor, and I do not know if it is generally true or not among the medical profession -- but at least once a year





1 that you should have a complete physical.

2 MR. COULTER: I agree that there should be  
3 some clause or regulation stating how many times because I  
4 have to think of the person who, maybe, likes to be sick and  
5 go to visit the doctor. Once he or she gets inside there,  
6 the doctor must say something to them and, therefore, charge  
7 them.

8 MR. BURT: I think the doctors get sick of  
9 those kind of people, too; doctors can get a little sick too.

10 MR. COULTER: On page 8, section 12 you say:  
11 "No attention whatever is paid to the problem of the great  
12 discrepancies in availability of medical care throughout the  
13 province, . . ." Are you now speaking of some of the outlying  
14 areas here?

15 DR. GOLDBERG: There is a great discrepancy  
16 between rural and urban ratios of physicians to population and  
17 obviously a prepayment plan will have some effect on this,  
18 depending on how it is set up. And we think that this is  
19 such a significant problem that the legislation should take this  
20 into account in its development.

21 MR. COULTER: I thought this was what you meant,  
22 but I wanted to make sure. Thank you.

23 Down a little further -- it is along the same  
24 line -- ". . . the apparent lack of leadership given to solving  
25 the acute problems of shortages of medical personnel and their



that you should have a complete physical.

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MR. COUNTER: On page 8, section 12 you say:

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Down a little further -- it is along the same

line -- " . . . the apparent lack of leadership given to solving



1 mal-distribution." Are you saying here that probably in our  
2 recommendations to the Minister there should be some way of  
3 distributing, say, specialists further afield than in the  
4 large cities?

5 DR. GOLDBERG: The legislation could include  
6 some inducements to make it more attractive for certain people  
7 to locate in place where they are needed. That is not only  
8 appropriate, but I think could fairly easily be done in the  
9 legislation.

10 MR. COULTER: I think that is all I have at the  
11 moment, Dr. Hagey.

12 THE CHAIRMAN: Thank you. I would like to  
13 interject a question here of my own. I get the impression, as  
14 I listen to this discussion here, that there are quite a number  
15 of places here where you are critical of general points; for  
16 instance, there not being enough physicians spread in the  
17 thinner-population part of the country. But you stop at your  
18 criticism here, rather than go further and suggest how these  
19 things may be taken care of. You say that they should be included  
20 in part of the Bill. But, how do you do it?

21 Now, we are going to be in a position, at some  
22 time, of not just criticizing, but of having to make specific  
23 recommendations and in any of these cases where you have made  
24 those general statements, do you wish to follow those up and  
25 say: Well, here is how you can do it specifically. It would



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1 be helpful to us in consideration of these recommendations.

2                   Likewise, I think that what you are suggesting  
3 here, wanting universal coverage, you must recognize is going  
4 to cost, somebody has suggested in this panel, in our discus-  
5 sions, somewhere in the neighbourhood of five million dollars,  
6 I think. And if you have any appreciation of what the cost  
7 is in the universal plan, then rather than just saying "cover  
8 it by taxes", how do you tax to get it? And, likewise, if you  
9 don't go all the way, then how do you provide for these lesser  
10 than desirable things that you have, but still desirable to  
11 be included and what would the cost be?

12                   DR. GOLDBERG: We would be very happy to submit  
13 an additional written submission to you, spelling out in detail  
14 our proposals on some of the areas that we have simply implied.

15                   THE CHAIRMAN: I think that this is coming out  
16 of these questions that are being asked. There is a concern  
17 here that you are making general statements without necessarily  
18 supporting them or showing how it is practical to overcome  
19 those things which you have criticized.

20                   MR. BURT: I think what we are really doing,  
21 Doctor, is pointing out things that we believe are not included  
22 in the Bill, which should have been included. I think there  
23 was a great deal of study put into the drafting of this Bill  
24 163 and it wasn't just done overnight. People who were experts  
25 in the field sat down and did what they considered to be a bang-



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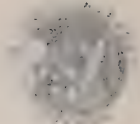


1 up job on it. But we are not concerned with what is left out  
2 of it. We are bringing these things to your attention in the  
3 hope that you gentlemen, who are very well-versed in this,  
4 can find some methods of dealing with it and agreeing with us  
5 that these things should be included in any piece of legislation.  
6 Maybe we are a little short on our recommendations, I will  
7 admit, but as Dr. Goldberg has said, we would be prepared to  
8 make specific recommendations. But we have pointed out in our  
9 criticism numerous places where we think these things are  
10 necessary and have been omitted in this legislation.

11 THE CHAIRMAN: Without speaking in defence of  
12 Bill 163, I get the impression that you are saying, in your  
13 brief, that we want a universal plan, but not wanting a universal  
14 plan, we would like to see Bill 163 adjusted so that it  
15 provides for practically everything that would be provided for  
16 in the universal plan. Is that about right?

17 MR. SPARKS: I think it is rather important here  
18 to see what the implicit difficulties are which you are raising  
19 in making this request. There are certain aspects of the  
20 problem of organized medical services which we have noted in  
21 the brief.

22 Specific questions have come up from Dr. Butt  
23 in relation to certain aspects in quality of care and other  
24 elements, and from Mr. Coulter relating to the well-baby care.  
25 There are elements then in the type of health services that we



up job on it. But we are not concerned with what is left out of it. We are bringing these things to your attention in the hope that you gentlemen, who are very well-versed in this,

Maybe we are a little short on our recommendations, I will admit, but as Dr. Goldberg has said, we would be prepared to make specific recommendations. But we have pointed out in our criticism numerous places where we think these things are necessary and have been omitted in this legislation.

THE CHAIRMAN: Without speaking in balance of

plan, we would like to see Bill 163 adjusted so that it provides for practically everything that would be provided for in the universal plan. Is that about right?

MR. SPARKS: I think it is rather important here

Specific questions have come up from Dr. Butts



1 are discussing in our brief in general outline that are not  
2 provided or could only be included in Bill 163 with almost  
3 a total alteration in the basic principles of Bill 163.

4 We can't provide an incentive to a physician  
5 to go into an undoctored area under Bill 163. As I see it  
6 now, Bill 163 is a subsidy program to enable people to purchase  
7 insurance and that physician will go to the area where he feels  
8 he can make a decent living and provide a decent service.

9 Now, a modification of the system that now  
10 operates to locate our physicians would then alter one of the  
11 principles of Bill 163.

12 THE CHAIRMAN: By "modification", you mean the  
13 payment of a salary directly by the government to the physician?

14 MR. SPARKS: Or any other agency. Obviously,  
15 under Bill 163, we couldn't request the carriers to undertake  
16 to handle the problem of the mal-distribution of health personnel.  
17 So, in attempting to expand on some of the general statements  
18 that we have made, you will appreciate that we will have to  
19 go beyond the inherent principles of Bill 163 in order to spell  
20 them out.

21 THE CHAIRMAN: Are you finished, Mr. Coulter?

22 MR. COULTER: Yes.

23 THE CHAIRMAN: Mr. Mulrooney?

24 MR. MULROONEY: I would like to ask a question  
25 about your recommendation No. 5, on page 1. It is not actually





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to go into an underserved area under Bill 163. As I see it

now, Bill 163 is a subsidy program to enable people to purchase

insurance and that physician will go to the area where he feels

he can make a decent living and provide a decent service.

Now, a modification of the system that now

operates to locate our physicians would then give one of the

principles of Bill 163.

THE CHAIRMAN: By "modification", you mean the

payment of a salary directly by the government to the physician

MR. STARKS: Or any other agency. Or jointly.

under Bill 163, we couldn't request the Ontario to undertake

to handle the problem of the maldistribution of health personnel

So, in attempting to expand on some of the general statements

that we have made, you will appreciate that we will have to

go beyond the inherent principles of Bill 163 in order to spell

them out.

MR. COUTER: Yes.

MR. MURPHY: I would like to ask a question

about your recommendation No. 5, on page 1. It is not actually



1 a recommendation. You state:

2 "The proposed legislation stifles

3 "initiative for developing new, better and

4 "more efficient ways to provide and finance

5 "health services in the province."

6 Am I correct in my guess that this relates  
7 to your recommendation No. 6, that the Act should be amended  
8 to provide financial and organizational aid for the establish-  
9 ment of medical group practice?

10 MR. SPARKS: That is right.

11 MR. MULROONEY: When, if and as -- and there is,  
12 as far as I am aware, only one such establishment in the  
13 province -- assuming that the doctors in such a group practice  
14 facility were willing to accept as patients persons covered  
15 either by a subsidy or otherwise, under this legislation, would  
16 this obviate what you see as the stifling effect of this  
17 legislation?

18 DR. GOLDBERG: No. We think the legislation has  
19 to go further and encourage the development of organized group  
20 practice. This again, Mr. Mulrooney, raises the question --  
21 we are not sure what Bill 163 says about how the Bill would  
22 affect a group practice organization. The legislation seems  
23 to us particularly cloudy in this area.

24 We not only want to allow the development of  
25 group practice; we want to encourage its development.



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23 to us particularly cloudy in this area.

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group practice; we want to encourage its development.





1 MR. MULROONEY: I think I agree with your  
2 idea on that score, Dr. Goldberg. But I would like an opinion  
3 from the delegation. If, for example, the Sault Ste. Marie  
4 group were recognized as a carrier -- whether a member of the  
5 Steel Workers' Union or from the community at large is free  
6 to use this type of facility to obtain his medical services,  
7 would this not obviate, to some extent, your objection?

8 DR. GOLDBERG: I suppose that we can assume that  
9 this is the nature of the Bill -- but, that is an assumption.  
10 It is not clearly indicated by the Bill itself.

11 MR. MULROONEY: There are many points to be  
12 covered and we have not come to grips with this problem at all,  
13 yet.

14 DR. GOLDBERG: That is correct.

15 MR. MULROONEY: We are looking for an opinion  
16 on this point from you and your organization.

17 DR. GOLDBERG: Even going along with what you are  
18 suggesting, if the legislation specifically allowed that, we  
19 think it should be further and provide funds for the development  
20 of group practice facilities.

21 MR. MULROONEY: Thank you.

22 MR. SPARKS: May I comment on No. 5. In  
23 addition to its relationship to No. 6, this illustrates the  
24 point we are talking about -- developing new, better and more  
25 efficient ways to provide and finance health services.



MR. MURDOCK: I think I agree with you.

from the delegation. If, for example, the Saint Joe Marie group were recognized as a carrier -- whether a member of the Steel Workers' Union or from the community at large is free to use this type of facility to obtain his medical services, would this not obviate, to some extent, your objection?

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MR. SPARKS: May I comment on No. 5. In

addition to its relationship to No. 6, this illustrates the point we are talking about -- developing new, better and more efficient ways to provide and finance health services.



1                   Such easy examples come to mind here in specific  
2 areas. Take the field of rehabilitation. Here we have a complex  
3 of facilities and services, medical, vocational, et cetera,  
4 that relate to the person in a state of ill-health and hoping  
5 to get back to productive employment. An effective rehabilitation  
6 program will provide a more efficient service. This integrates  
7 the medical component of care, the re-training component, the  
8 necessary home care involved, the replacement of the worker,  
9 and so on. This is the one example of the type of thing that  
10 is implicit in our replies.

11                   Another aspect of the use of para-medical personnel  
12 which you get in group practice is such things as sight and  
13 hearing clinics. This is a major problem amongst school  
14 children. It could be handled under medical supervision, by  
15 technicians, and this means an integrated problem. This means  
16 that the profession sits down with the health officials and  
17 the official health agencies and says: "This is the kind of  
18 hearing and sight program we will conduct in our school" -- and  
19 what is going to happen to the children. "Having gone through  
20 the program, we will require some additional medical services."  
21 This is the kind of thing we are talking about here, the  
22 economical use of what is a very limited number of skills in  
23 health care.

24                   MR. MULROONEY: Thank you, Mr. Chairman.

25                   THE CHAIRMAN: Mr. Whitney?





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health care.



1 MR. WHITNEY: First of all, I commend the  
2 Chairman on the statement he made concerning the entire brief.  
3 I think he put my difficulties in probably better language than  
4 I would have selected myself.

5 I feel your brief has stated, generally, certain  
6 goals to be attained, has outlined certain ideals that you hold  
7 and it goes so far as to critically -- and I use the word in  
8 a technical sense -- point out the vacuums, and so on, that  
9 do exist. But the language of the brief does not help me on  
10 matters that are specific we might like to hear as a Committee.

11 Just as a quick example, on page 1 of your  
12 main conclusions, you state, in No. 5 that:

13 "The proposed legislation stifles initiative  
14 "for developing new, better and more efficient  
15 "ways to provide and financial health services  
16 "in this province."

17 Now, just to kick that around a bit, I feel,  
18 myself, and I think most people do, that any sort of legislation  
19 that goes on to do something in the interests of spreading  
20 and popularizing the use of health services does not really  
21 have a stifling effect -- it has an encouraging effect. This  
22 points up a difference in view between us, when I read your  
23 brief, and if there is any particular thing that you think in  
24 the Bill causes a stifling effect, then the Committee would  
25 like to hear just in what manner there is a stifling effect so



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1 that we, in our recommendations, can get rid of this stifling  
2 effect.

3 This sort of example is the kind of thinking  
4 I have done all through this brief and it would take us several  
5 days to take it line by line and try to draw out specifics,  
6 and maybe you are not ready and willing to make specific  
7 recommendations. But I think it would be more helpful to this  
8 Committee and to us, rather than extenuate the questioning  
9 period on this, if you can give us, under your principal  
10 recommendations, some sort of specific recommendations so  
11 that then we can consider whether this is proper drafting for  
12 a Bill or something to go into regulations.

13 I get the impression that you are pretty much  
14 against regulations, but I can assure you that the lawyers would  
15 probably say that you can't possibly do a Bill like this without  
16 having fairly extensive regulations.

17 So I think you have to look at it in a practical  
18 way, in making these recommendations to us and I, for one,  
19 would like to see you go further, now that you have pointed up  
20 the goals to be obtained, and tell us a little more specifically  
21 how we can get there. This, I think, would be very helpful  
22 to the Committee.

23 Just one question, Mr. Chairman. What kind of  
24 coverage does the Union have now under its group contracts  
25 in this field?



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23 coverage does the Union have now under the group contracts

24 in this field?



1 MR. BURT: In a lot of larger contracts, we  
2 have complete medical coverage, which includes doctors' visits  
3 at home and in-hospital, for wherever the doctor is necessary,  
4 we have a coverage. Under the Windsor Medical, we also have  
5 eye examinations and physical examinations as well. That is  
6 just under Windsor Medical which covers a very substantial  
7 proportion of our membership in Western Ontario. And this is  
8 employer-paid.

9 MR. WHITNEY: Mostly under Windsor Medical and  
10 P.S.I.?

11 MR. BURT: Yes.

12 DR. GOLDBERG: We point out in the brief, Mr.  
13 Whitney, that 95% of our members are covered by service plans  
14 such as P.S.I. or Windsor Medical. As a matter of fact, the  
15 UAW is in the forefront encouraging the service approach to  
16 medical care. We want this approach extended.

17 MR. BURT: What we do when we negotiate our  
18 programs, we decided to push for service rather than a private  
19 plan on a basis of how much money was available for what we  
20 could buy from private carriers and I think, as a result of that  
21 decision and with the co-operation of the employers in meeting  
22 our requests for services, that we were instrumental in  
23 extending the services provided by those plans because they  
24 had a guaranteed and secure income and they had sufficient  
25 leeway on that basis to extend the services and, from time to time,





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1 they have done that. That also included the Blue Cross.  
2 After the Ontario Hospital Services Act was passed, we, of  
3 course, adopted that and extended that to include the semi-  
4 private accommodation and that was done by collective bargaining.

5 MR. WHITNEY: Thank you, Mr. Chairman.

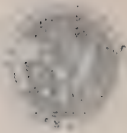
6 THE CHAIRMAN: Just to follow up Mr. Whitney's  
7 question with one further question: Am I right in assuming  
8 that even the best contract or contracts that you now have do  
9 still not go far enough, in your opinion?

10 MR. BURT: That is true. They are not  
11 comprehensive, but we are concerned more with the people who  
12 are not covered in any way. While our membership are covered  
13 under the most adequate coverage we can buy, there are so many  
14 thousands of people who are not covered and we are concerned  
15 about those people.

16 THE CHAIRMAN: On what you think is the most  
17 comprehensive coverage that you now have in any of the contracts  
18 that the Union has, would you care to send us a copy of that  
19 contract?

20 MR. BURT: Yes. But we will have to also add  
21 a rider to any material we are sending because in 1964 our  
22 agreements are opening up again and we are probably going to  
23 bargain for some more coverage.

24 THE CHAIRMAN: I think it is quite evident that  
25 what you are aiming at is universal coverage?



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1 MR. BURT: Yes.

2 THE CHAIRMAN: And anything less than that,  
3 you are not going to be satisfied with?

4 MR. BURT: No.

5 DR. BUTT: This is the only place where  
D/MR/RPS 6 I find a real, specific recommendation. You want 50% paid  
7 by the Government of any premium, and then you say you do not  
8 want any interference with any arrangements you now have. You  
9 just got through saying you want a hundred per cent paid by  
10 the Government. Now would you please -- these I can follow,  
11 these figures -- now would you explain just what you do mean  
12 then? You are going to have another 50% from the Government.  
13 Where do you put this money?

14 MR. BURT: We will find a place to put it.

15 DR. BUTT: That is all I wanted to know. Thank  
16 you very much. You explained it very well.

17 MR. NAYLOR: There is just one point, Mr.  
18 Chairman, Dr. Goldberg I believe that you answered a question  
19 of Dr. Butt's a little while ago about the proportion of doctors'  
20 fees covered by the sort of service-type plan in this Hamilton  
21 study, I think you quoted 58%. I wondered if I understood you  
22 correctly because I find that a little hard to understand.  
23 Would it not be true that the complete plan of P.S.I. of Windsor  
24 Medical would cover more than 58% of the doctors' fees? Where  
25 is the extra 42%?

THE CHAIRMAN: And anything less than that.

MR. BUTT: No.

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5 the discontinuity there. That is one thing.

6 The other thing is P.S.I. was a service plan  
7 which was examined and in this particular case there was no  
8 service contract with specialists to provide full payment.  
9 That is another element where additional costs were involved,  
10 and another element is that certain people in this particular  
11 community, certain physicians were not member doctors, particip-  
12 ating doctors in the service plan and, therefore, had additional  
13 charges.

14 These are all areas to show that -- simply the  
15 evidence showed that the plan was not paying the full cost of  
16 the physician charges which were being rendered to the people  
17 who were being examined.

18 MR. WHITNEY: Doctors should not get overtime?

19 DR. GOLBERG: Overtime or overcharges?

20 MR. NAYLOR: The item then affects not only  
21 people who were employed all the time, but other people I take  
22 it?

23 DR. GOLDBERG: People who were laid off during  
24 a portion of the year.

25 MR. NAYLOR: Oh I see.



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1 MR. SPARKS: The evidence from your own Ontario  
2 Hospital plan will indicate the relationship between lay-off  
3 and drop-off and private care as well. When they cannot meet  
4 the premium costs during the period of lay-off, this is one  
5 of the things that the healthy worker would take the risk of.  
6 Evidence from your Ontario Hospital Service Commission will  
7 show the drop-off in the proportion of voluntary enrollment  
8 during a period of continued unemployment.

9 DR. BUTT: Would this be one of the areas in which  
10 you would like to enter into negotiations? I mean this is  
11 apparently coming up, this sort of thing and you might readily  
12 get into this area.

13 DR. GOLBERG: In terms of lay-off?

14 DR. BUTT: Listening to his comments, yes.

15 MR. BURT: We have difficulty too during the  
16 lay-off period -- we have so many instances where the people  
17 drop the coverage, and this is the time they need it most. You  
18 think they would make sure they paid for that.

19 MR. NAYLOR: You mean the employers ?

20 MR. BURT: I mean on the lay-off the employer's  
21 responsibility ceases after a certain period of time, maybe  
22 for a month, month in which the lay-off occurred. If the  
23 lay-off occurs at the first of the month, be the end of the  
24 month; after the fifteenth generally continued on for another  
25 month but in our industry they have seasonal changeover periods



MR. SPARKS: The evidence from your own Ontario

1. evidence will show that the proportion of voluntary

2. drop-off and lay-off is very small and that

3. the premium costs during the period of lay-off, this is one

4. of the things that the healthy worker would take the risk of.

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24. month but in any case, the responsibility is not





1 and they have quite often lengthy periods of time of lay-off and  
2 the automobile business is up and down anyway so that they  
3 drop their coverage when they are laid-off, and they don't  
4 seem to see their way clear to paying for it themselves.

5 DR. BUTT: Would you be interested in filing  
6 specifically how you think this might be dealt with?

7 DR. BURT: Yes. We come back to the same old  
8 thing. It sounds like a record. We think the answer to this  
9 problem is the universal coverage, paid for through some  
10 method of taxation on an ability to pay.

11 I don't see any other answer for this thing  
12 because, may I add to something that was mentioned before when  
13 I said we would find a place for the money. What happens in  
14 the collective bargaining field is there is so much money  
15 available, and a proportion of that is assigned to wages and  
16 a proportion to the fringe benefits and you often see a state-  
17 ment in the press our fringe benefits are 56¢ an hour, something  
18 like that.

19 We have to remember too that those things are  
20 bargained for and if you have got a package, you are going to  
21 have to take so much out of that to pay for medical care so  
22 actually the money belongs to the worker anyway. If he did  
23 not get it there, he would get it somewhere else.

24 Some of the other unions such as the building  
25 trades, for example, where they are moved from place to place have

the automobile business is up and down anyway so that they drop their coverage when they are laid-off, and they don't pay for it until they get back to work.

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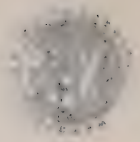
1 not gone for these fringe benefits in the same way as we have  
2 in our industry, and as a result their rates of pay are quite  
3 a bit higher, their hourly rates, and they pay for their  
4 services from their pay envelope. This is a better way to  
5 do it, in our opinion, because it sets up a uniform system of  
6 health care for our people that they probably would not contrib-  
7 ute to on a voluntary basis, and that is one of the difficulties  
8 with a voluntary health care and we say that this other method  
9 is much more desirable and takes care of our problems too.

10 If there is any money left over, we will  
11 probably put it in pensions. I don't know. By the look of  
12 things, the way they are starting to reduce pensions, they will  
13 need it.

14 MR. SIMON: Just one or two questions, Mr. Chair-  
15 man, on page 16, paragraphs 31 and 32, and I believe it goes  
16 into 34, you speak about over-billing, inflationary prices,  
17 increases and spirals in utilization, and so on. And my  
18 question is what is meant by all that? Mr. Goldberg or Mr.  
19 Sparks?

20 MR. SPARKS: Well I think it really starts on  
21 para. 30, and this is an example of one of the difficulties there  
22 is that we had examined in the Bill, and thus it came up in  
23 the form of a question rather than a solution. It is not  
24 clear to us in reading the Bill if the Bill is desirous of  
25 providing a full-service benefit. The Bill anticipates, and makes





1  
2  
3  
4 services from their pay envelope. This is a better way to  
5 do it, in our opinion, because it sets up a uniform system of  
6 health care for our people that they probably would not contrib-  
7 ute to on a voluntary basis, and that is one of the difficulties  
8 with a voluntary health care and we say that this other method  
9 is much more desirable and takes care of our problems too.  
10 If there is any money left over, we will  
11 probably put it in pensions. I don't know. By the look of  
12 things, the way they are starting to reduce pensions, they will  
13  
14 MR. SIMON: That one or two questions, Mr. Chair-  
15 man, on page 16, paragraphs 31 and 32, and I believe it goes  
16 into 34, you speak about over-billing, inflationary prices,  
17 increased and spirals in utilization, and so on. And my  
18  
19  
20 MR. SPARKS: Well I think it really starts on  
21 para. 30, and this is an example of one of the difficulties there  
22 is that we had examined in the Bill, and thus it came up in  
23 the form of a question rather than a solution. It is not  
24 clear to us in reading the Bill if the Bill is desirous of



1 certain assumptions -- through the competition of multiplicity  
2 of carriers there is some benefit to the public. We would  
3 challenge that on other grounds. One of the obvious benefits  
4 to the public is the patient at the point of service is the  
5 non-profit point. As you know, you have a contract with  
6 physicians under which the physician agrees to accept the  
7 payment by the plan in full settlement of his account. The  
8 private carrier has no such arrangement and is not in a position  
9 to obtain such arrangements from the provision, so what we  
10 are really asking in 30 and 31: is there going to be encourage-  
11 ment under this whereby so-called over-billing and extra-billing  
12 is eliminated or controlled and how is it to be undertaken  
13 within the principles which the Bill establishes, namely,  
14 multiplicity of carriers without a contract with a physician?

15 I think this is what we mean sir. Is that  
16 on your point?

17 MR. SIMON: You are talking about a fee schedule?

18 MR. SPARKS: Well no matter what the method of  
19 payment is we trace out in 30 the questions that are raised  
20 concerning what is anticipated in this Bill in respect of  
21 arrangements between providers of service, on the one hand,  
22 and the carriers on the other in regard to the payment made for  
23 the covered service.

24 We are simply wondering if there is going to  
25 be a discrimination between the two types of carriers anticipated



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ment for other carriers to come in and take over the business  
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the covered service.  
We are simply wondering if there is going to





1 in the Bill. This is one area where the competition between  
2 carriers is purported to be of some advantage to the patient.  
3 That is what we were getting at sir.

4 MR. SIMON: Now item 34 you speak about the  
5 change in fees, the revision of fees after the initial two  
6 years, and you are concerned, according to this, with the  
7 arbitrary and unilateral authority given to the physician  
8 in setting of fees. I can understand this much. What are  
9 your views in regards to further periods or stabilization  
10 periods for the setting of fees after the initial two years?  
11 Do you think it would be open every year, as contemplated by  
2 12 the Act or some other arrangement?

13 MR. SPARKS: Basically I think this area is  
14 an area that obviously has to be negotiated. Otherwise, the  
15 so-called maximum rate to which the superintendent must give  
16 his consent, or arbitrate on is a bit of a farce. On the  
17 one hand, after the initial period of two years, or after,  
18 you have closed the price system. Therefore, if, as I under-  
19 stand, the Bill contemplates that a carrier can go back to  
20 the superintendent and ask for an increase in the maximum rate,  
21 the carrier has not control over the unit price. The patient,  
22 on the other hand, is receiving the service, and this is only  
23 the utilization part of his Bill.

24 The Ontario Medical Association is establishing  
25 the price or changes in the price for the carrier and in this case



That is what we were getting at sir.

MR. SIMON: Now item 34 you speak about the

change in fees, the revision of fees after the initial two

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1 the only thing he does is go back to the superintendent and  
2 throw up his hands and say "here is our experience." Then the  
3 maximum goes up and the public subsidy increases in proportion  
4 to it. That is why we suggest this, although we do not suggest  
5 it here, we state that we do not agree this is the proper  
6 system even within the confines of Bill 163. This would have  
7 to be negotiated and settled as it is with public programs,  
8 such as Workmen's Compensation. That is what we are getting at  
9 in 34.

10 MR. CASWELL: Mr. Chairman, for information  
11 and clarification I would like to ask one or two questions. The  
12 first is the O.H.S. which is now operated on a contributory  
13 basis is certainly, in my opinion and those of many others, a  
14 very satisfactory situation. Do you not approve of this method  
15 of contributory payment to O.H.S.? Do you think O.H.S. should  
16 be paid for, the Ontario Hospital Services on a hundred per cent  
17 basis the same as you are suggesting the medical?

18 DR. GOLDBERG: When the hospital plan was being  
19 discussed, we proposed the hospitalization should be financed  
20 out of general revenue with no direct premium payment. We  
21 would prefer such a system, yes sir.

22 MR. CASWELL: The other thing I would like to  
23 ask is, I am not quite clear, because of lack of knowledge I  
24 am sure, you are suggesting establishing a medical group practice  
25 -- I assume you mean a clinic -- where there is a medical clinic





the only thing he does is go back to the superintendent and throw up his hands and say "here is our experience." Then the system even within the confines of Bill 103. This would have to be negotiated and settled as it is with public programs, such as Workmen's Compensation. That is what we are getting at in 34.

MR. CASWELL: Mr. Chairman, for information and clarification I would like to ask one or two questions. The first is the O.H.S. which is now operated on a contributory of contributory payment to O.H.S.? Do you think O.H.S. should be paid for, the Ontario Hospital Services on a hundred per cent basis the same as you are suggesting the medical?

DR. GOLDBERG: When the hospital plan was being discussed, we proposed the hospitalization should be financed out of general revenue with no direct premium payment. We would prefer such a system, yes sir.

MR. CASWELL: The other thing I would like to ask is, I am not quite clear, because of lack of knowledge I



1 operated by the employer, or operated by the union, and if they  
2 have an insurance plan, should they not pay for service through  
3 the insurance plan the same as they would if they did not have  
4 that clinic?

5 DR. GOLDBERG: We don't know what Bill 163  
6 contemplates.

7 MR. CASWELL: But at the present time the  
8 employees are covered through a carrier and the company-operated  
9 clinic. Could they not be paid by the carrier for the particular  
10 service?

11 DR. GOLDBERG: In some cases that we know of the  
12 plan itself is the carrier. There is no fee-for-service  
13 payment made to the group practice at all. There is simply a  
14 premium paid to the group practice and the physicians are  
15 remunerated on a number of different bases but there is no  
16 payment on a fee-for-service to the plan.

17 We don't know what Bill 163 contemplates doing  
18 about payment to such organizations such as group practice.  
19 We think it is unclear.

20 MR. CASWELL: You are recommending the medical  
21 clinics though?

22 DR. GOLDBERG: Yes, very definitely.

23 MR. CASWELL: My understanding, and again I may  
24 be wrong, but recently the Steelworkers negotiated a contract  
25 on behalf of their employees of nickel, eliminating the clinic,



the insurance plan the same as they would if they did not have that clinic?

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be wrong, but recently the Steelworkers negotiated a contract





1 and having their employees under a P.S.I. plan. Is this  
2 contrary to your thinking?

3 MR. BURT: Where is that?

4 MR. CASWELL: In Sudbury.

5 MR. BURT: In Sudbury?

6 MR. CASWELL: Yes. They had a company medical  
7 clinic for years.

8 MR. BURT: I would have no way of answering that  
9 because this is the first I have heard of it and I don't know  
10 what the situation or the background of their decision would  
11 be.

12 MR. CASWELL: The employees now are all under  
13 P.S.I. contracts.

14 MR. SIMON: They will be here tomorrow Mr.  
15 Chairman.

16 MR. BURT: They eliminated the clinic? If they  
17 are here tomorrow, you can get a really good answer from them.  
18 Quite frankly I would not know why.

19 MR. CASWELL: It came through the union. This  
20 is why I wondered.

21 MR. BURT: I do know they operated a clinic.  
22 I believe it is at Sault Ste. Marie.

23 MR. CASWELL: That is right.

24 MR. BURT: And I understand that that one is  
25 in full force and effect and going very strongly. Is that not so?



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13 in full force and effect and going very strongly. Is that not so?



1 MR. CASWELL: That one, Mr. Burt, was operated  
2 by the union.

3 MR. BURT: It was operated by the union? You  
4 are talking about a company-operated clinic?

5 MR. CASWELL: Company operated in Sudbury.

6 DR. GOLDBERG: I am not so sure tomorrow when  
7 you hear from this group, they will agree that this statement  
8 is absolutely correct. I understand there is an independent  
9 association which owns and operates a medical centre in Sault  
10 Ste. Marie. It is not owned or run by the union. I don't  
11 know the details of the story there at all. I think you should  
12 ask them.

13 MR. CASWELL: I just wondered, they are both  
14 the same steel union, I wondered why they didn't seem to get  
15 together.

16 DR. GOLDBERG: Mr. Caswell, in answer to the  
17 point you made we wondered, for example, under Schedule A what  
18 point 12 means where it says service rendered by physicians  
19 pursuant to arrangements for rendering service to the employees  
20 of an employer or the employees of an association is an excluded  
21 service under the Act. We are not clear what this language  
22 means. How does that then relate to a place like the INCO  
23 clinic, for example? We don't know how it would effect us.

24 MR. CASWELL: The other thing that I suspect,  
25 I may be wrong, if you receive over a hundred per cent payment





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1 MR. CASWELL: That one, Mr. Bunt, was operated  
2  
3 MR. BUNT: It was operated by the union? You  
4  
5 MR. CASWELL: Company operated in Sydney.  
6  
7 DR. GOLDBERG: I am not so sure tomorrow when  
8 you hear from this group, they will agree that this statement  
9 is absolutely correct. I understand there is an independent  
10 association which owns and operates a medical centre in Sanif  
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22 service under the Act. We are not clear what this language  
23 means. How does that then relate to a place like the INGO  
24 clinic, for example? We don't know how it would affect us.  
25 MR. CASWELL: The other thing that I suspect,  
26 I may be wrong, if you receive over a hundred per cent payment



1 by the Government or 50%, as you used as an alternative, where  
2 you have a contract that the employer pays 100%, it would not  
3 mean an additional 50%. In other words, the Government would  
4 pay 100%, the employer would pay 100% of the 50%. Isn't that  
5 correct? He would pay the balance as he does now.

6 MR. BURT: We would have to renegotiate the  
7 whole thing on that basis. I think we did that actually when  
8 the Ontario Hospital Services plan came into effect. We were  
9 all tied up with Blue Cross at that time and previous to that  
10 we had insurance plans, and so on, and this opened up the  
11 whole thing as far as negotiations are concerned.

12 MR. CASWELL: What I am getting at, in effect,  
13 the Government pays 50% or if they pay 100% the employer would  
14 still pay his portion of that through his taxes, so he is going  
15 to pay 100% of the balance as he does now.

16 MR. BURT: There would not be any extra burden  
17 on the employer.

18 MR. CASWELL: You don't think so?

19 THE CHAIRMAN: Any further questions?

20 MR. MAJOR: I have a question I would like to  
21 ask Mr. Burt. I would like to refer to page 23, paragraph 46.  
22 I would like to consider that paragraph in relation to the  
23 paragraph at the top of page 5 and in relation to recommendation  
24 8, I guess it is on page 2. There has been a lot of discussion  
25 and a lot of questions and answers in respect to fee schedules,



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MR. CASWELL: You are right.

THE CHAIRMAN: Any further questions?

MR. MAJOR: I have a question I would like to  
ask Mr. Burt. I would like to refer to page 23, paragraph 46.

I would like to know what paragraph is referred to in

paragraph 46 on page 23. I am in position to answer that

8, I guess it is on page 2. There has been a lot of discussion

and a lot of questions and answers in regard to the subject.





1 service work, participating physicians' agreements, and so on.

/PB/RPS 2                   Coming down to your main endeavour of having  
3 a full-scale plan paid for through taxes on some kind of  
4 equitable system of taxation, and I am not sure whether I  
5 understand what an equitable system is, I am wondering if your  
6 ideas as expressed in these paragraphs lead you ultimately  
7 to the position so that there will be no extra billing, similar  
8 to the service plan today, but with doctors under agreement  
9 with the Government. Is this what this would lead us to?

10                   MR. SPARKS: It is a little difficult to follow  
11 your question, Mr. Major. You started off with reference to  
12 No. 46 and refer to earlier comments concerning over-billing  
13 and the full service concept. I think that answer to the  
14 question of whether we would favour the full service plan is  
15 obviously yes. We hope we dissuaded you from any idea we are  
16 interested in patching up the insurance system. What we are  
17 here for, our proposal is a universal program and a universal  
18 program would include the full range of medical and related  
19 health services and would provide full service benefits. As  
20 to the last statement you made concerning some form of agreement  
21 between -- I didn't get your specific words, between organized  
22 medicine and public authority.

23                   MR. MAJOR: Add nurses.

24                   MR. SPARKS: The answer is yes.

25                   MR. MAJOR: And physiotherapists et cetera,



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a full-scale plan paid for through taxes on some kind of

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between -- I didn't get your specific words, between organized

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MR. SPARKS: The answer is yes.

MR. MAJOR: And physiotherapists of course.



1 druggists and so on -- what you want is a compulsory plan paid  
2 for on an equitable taxation system and it is, in essence, a  
3 contract between the providers of the services and the  
4 Government.

5 MR. SPARKS: Mr. Chairman, the answer to your  
6 question is yes. Let us not play around with words like contracts.  
7 In Saskatchewan today there are a very substantial number of  
8 physicians who have no contract whatsoever with the Government  
9 to provide services under the Medical Care Insurance Act, but  
10 provide these services on a full-service basis by an arrangement  
11 with the respective carriers that are established there.

12 This, in fact, has established a sort of pipeline  
13 between the medical profession and the physician on the one  
14 hand. The carriers have no source of income other than what  
15 they receive from the Government. They make no payment to the  
16 physician other than what they receive from the Commission. The  
17 contractual relationship is such that the physician is providing  
18 the care to a patient as a member of the agency instead of  
19 payment by the individual. If you are attempting to imply that  
20 our position is that we would negotiate an individual contract  
21 with the physician, that is not our position. If you want  
22 us to express whether it could be, there are a variety of  
23 contractual arrangements which would be suitable to the  
24 physician.

25 MR. MAJOR: Let us look at Saskatchewan for a





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MR. MAJOR: Let us look at Saskatchewan for a



1 minute. If a physician in Saskatchewan renders services to a  
2 citizen of that province is he confined to a certain type of  
3 billing?

4 MR. SPARKS: You have to tell me . . .

5 MR. MAJOR: Is he confined to a schedule?

6 MR. SPARKS: You have to tell me, first of all,  
7 what the status of the patient is. The Saskatchewan situation  
8 operates in terms of the status of the patient and the  
9 relationship that the patient and the doctor have contracted  
10 in for the rendering of the individual services. If the physician  
11 bills directly it is the same rate of payment that the College  
12 of Physicians and Surgeons have. If the patient has paid  
13 \$5 and joined the voluntary health, approved health agency as  
14 it is called then the physician, the plan and the patient  
15 operate under the Act. The patient agrees to accept the  
16 full settlement of the College of Physicians and Surgeons as  
17 made by the physician to the approved health care agency who  
18 passes it on to the doctor. Where the patient is a member  
19 of an approved health agency the physician will not bill the  
20 plan direct. He then may provide the patient with a bill which  
21 lists out six items of identification for the patient.

22 The patient pays his bill and gets reimbursed  
23 from the Commission at the same rate and based on the same  
24 fee schedule that applies in respect of the other type of payment.

25 MR. MAJOR: You don't want any voluntary agencies



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1 in Ontario?

2 MR. SPARKS: Sir, our . . .

3 MR. MAJOR: Page 23.

4 MR. SPARKS: We don't want a voluntary insurance  
5 system. We feel this will meet the objective we have, a subsidy  
6 for an undefined group of needy people.

7 MR. MAJOR: Let us go back to the original  
8 proposition: the fact there is some variation in Saskatchewan,  
9 we don't want this variation on the coverage in Ontario, from  
10 what I understand. Let us take one, the main purveyor  
11 of health services in Ontario, the medical profession. If  
12 we have a universal compulsory proposition the question I am  
13 putting to you, wouldn't it be reasonable that a physician would  
14 work under the direction of the Government, written or implied  
15 contract relationship. I also indicated in my original state-  
16 ment that a fee schedule would have to be negotiated. This was  
17 a statement. Is this so? Is this what you are looking for,  
18 that the physician literally becomes a public servant?

19 MR. SPARKS: Sir, I don't think this argument  
20 is added to in any way by the use of such terms of public  
21 servants. What I attempted to say was in the confines of this  
22 Bill there is no mechanism implied or stated which will control  
23 changes in the price the medical service costs other than the  
24 authority given either to the superintendent to approve the  
25 maximum rate or shove it over to arbitration. I say in a universal



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1 program some arrangement must be made to handle that problem,  
2 some arrangement must be set up which would establish the  
3 batting rules concerning modifications in the fee schedule.

4 MR. MAJOR: I am not worrying about that. I  
5 am trying to resolve the statements you have made on various  
6 points. If you bring them together as a whole it looks to me  
7 what you are proposing is a compulsory health service, to take  
8 a person or a class of people who are purveying health services  
9 and put them under the control directly of Government, so  
10 you wouldn't have any extra billing, so you could control  
11 quality, so you would legislate if a doctor was needed in  
12 Hoboken he should get there.

13 MR. SPARKS: I didn't say that.

14 THE CHAIRMAN: If I may ask a question, to  
15 interject and try to clear this up, you have suggested this  
16 universal plan, one hundred per cent paid by Government. You  
17 have questioned things that are in the Bill here now. You  
18 have discussed the Saskatchewan plan. You haven't committed  
19 yourself to say that the Saskatchewan plan is a model which  
20 we would recommend here. You haven't stated specifically what  
21 you would recommend here other than in very general terms.  
22 I think Mr. Major is trying to find out how far you have gone  
23 in your thinking. Am I right in either deducting one or two  
24 things: that you haven't carried your thinking to the extent  
25 that you know exactly what you would recommend in these various



1 program some arrangement must be made to handle that problem.

2 some arrangement must be set up which would establish the

3 battling rules concerning modifications in the schedule.

4 MR. MAJOR: I am not worrying about that. I

5 am trying to resolve the statements you have made on various

6 points. If you bring them together as a whole it looks to me

7 what you are proposing is a compulsory health service, to make

8 a person or a class of people who are providing health services

9 and put them under the control directly of government, so

10 you wouldn't have any extra billing, so you could control

11 quality, so you would legislate if a doctor was needed in

12 MR. STARO: I didn't say that.

13 THE CHAIRMAN: If I may ask a question, to

14 intersect and try to clear this up, you have suggested this

15 universal plan, one hundred per cent paid by government. You

16 have questioned things that are in the bill here now. You

17 have discussed the Saskatchewan plan. You haven't committed

18 yourself to say that the Saskatchewan plan is a model which

19 we would recommend here. You haven't stated specifically what

20 you would recommend here other than in very general terms.

21 I think Mr. Major is trying to find out how far you have gone

22 in your thinking. Am I right in either deducting one or two

23 that you haven't carried your thinking to the extent

24 that you would recommend in these various



1 things that you have questioned or that you are not prepared  
2 to state what your thinking is.

3 MR. BURT: I think the question raised was  
4 under our proposal doctors would become nothing but public  
5 servants. That seems to be one suggestion that is indicated  
6 by Mr. Major. The hospital employees are not public servants.  
7 They are under the Provincial plan. People who do work on the  
8 Parliament Buildings on Queen's Park are not public servants,  
9 I don't think. They work for a contractor, and I imagine  
10 some arrangement is made between the Government and the  
11 contractor in order to do the work. Our proposal is not  
12 that doctors would become public servants just because we  
13 advocate and recommend a universal coverage paid for by some  
14 equitable form of taxation based on ability to pay. Otherwise  
15 the people who need attention are not going to get it.

16 THE CHAIRMAN: I am not trying to embarrass  
17 you. I do suggest that you are ducking the question here which  
18 is a question for clarification. It was have you gone far  
19 enough in your thinking, and I don't think if you haven't you  
20 need have any hesitation in admitting it, to recommend specific  
21 plans at this point. You are simply, as I understand it  
22 recommending study of these things that you have questioned and  
23 the only recommendation is that these things ought to be discus-  
24 sed and negotiated to find answers to the questions that you  
25 have posed to us.



MR. BURR: I think the question raised was

under our proposal doctors would become nothing but public

servants. That seems to be one suggestion that is indicated

by Mr. Major. The hospital employees are not public servants.

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THE CHAIRMAN: I am not trying to embarrass

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1 MR. BURT: I would suggest that proper  
2 attention given to the whole brief would indicate we don't  
3 propose what has been suggested. It didn't flow out of our  
4 suggestions in our brief, and we do make specific recommendations  
5 in our 15 points about what the Act should include. There are  
6 certain places in the Act we fail to make recommendations,  
7 just for the simple reason the Act itself it not clear. I  
8 don't know how we could make recommendations on things that  
9 are in a piece of legislation when the legislation itself  
10 does not cover what it is apparently intended to cover. We  
11 were somewhat stuck in dealing with your terms of reference,  
12 which you are a little confined by, when trying to develop our  
13 program in such a way to indicate what we should do, because  
14 we believe we are beyond the points of your terms of reference.  
15 I don't think that our program envisages at all  
16 the suggestion that all doctors would be paid a salary by  
17 Government. That would be the quickest way to do it rather than  
18 beating all around the bush the way it has been suggested and if  
19 doctors want to be public servants. The best way would be for  
20 doctors to agree and the Government take them all over and  
21 pay them salaries. We are not proposing that at all. The  
22 suggestion that comprehensive coverage be given through a  
23 method of taxation is not an unusual suggestion. We are not  
24 pioneering in that field in respect of medical care, I don't  
25 believe. I don't follow the line of questioning that suggests

MR. BURR: I would suggest that proper

suggestions in our brief, and we do make specific recommendations in our 15 points about what the Act should include. There are certain places in the Act we fail to make recommendations, just for the simple reason the Act itself is not clear. I don't know how we could make recommendations on things that are in a piece of legislation when the legislation itself does not cover what it is apparently intended to cover. We were somewhat stuck in dealing with your terms of reference, which you are a little confused by when trying to develop our program in such a way to indicate what we should do, because

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1 that, frankly.

2 THE CHAIRMAN: I don't think there is much use  
3 in my pursuing this further. I would suggest that the state-  
4 ment you are making are negative. You said we don't suggest  
5 this, we don't suggest that. I think what the members of the  
6 Enquiry have been trying to find out is the positive approach  
7 to this. You say we don't suggest that the doctors be paid  
8 by Government, but you don't say how you do suggest that they  
9 be paid. That is what I see as our problem here.

10 MR. BURT: I think through an agency. It is  
11 quite true in Windsor Medical or P.S.I. doctors are not paid  
12 by Governments, but they are paid by the agency. One of the  
13 difficulties there is the agency is controlled by the doctors.  
14 We have been trying for years to get representation on that  
15 group. We haven't got it yet. We have nothing to say about the  
16 manner in which rates are set. We have accepted it because that  
17 is the best method we have had so far. Doctors are in agreement  
18 with that. They don't bill the patients. They bill the  
19 Association. I would say that there is a variety of methods  
20 by which the taxation dollar could be used to pay doctors. I  
21 don't think that presents any insurmountable problem. It could  
22 be done through an agency.

23 DR. BUTT: Excuse me, may I interrupt. One  
24 positive thing and you may either agree or disagree. Some of  
25 the other briefs have suggested an advisory committee on which





THE CHAIRMAN: I don't think there is much use

in continuing this discussion. I don't think we can

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this, we don't suggest that. I think what the members of the

Enquiry have been trying to find out is the positive approach

to this. You say we don't suggest that the doctors be paid

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quite true in Windsor Medical or P.I. doctors are not paid

by Government, but they are paid by the agency. One of the

difficulties is that the agency is not a government agency.

It is a private agency. It is not a government agency.

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manner in which rates are set. We have accepted it because that

is the best method we have had so far. Doctors are in agreement

with that. They don't bill the patients. They bill the

Association. I would say that there is a variety of methods

by which the taxation dollar could be used to pay doctors. I

don't think that presents any insurmountable problem. It could

be done through an agency.

DR. HAYES: Excuse me, may I interrupt. One

question I want to ask you is whether or not the

taxation dollar could be used to pay doctors.



1 there would be consumer representation, physician representation,  
2 carrier representation and the people who are administering  
3 it. Does this meet with your approval or would you be permitted  
4 to think of this or doesn't it go far enough? Give us one  
5 thing that would be positive and we can go on.

6 MR. BURT: I would imagine it would be very,  
7 very useful.

8 MR. SIMON: In reading the brief it is one of  
9 the recommendations.

10 MR. BURT: That is right.

11 MR. SPARKS: I think the advisory committee  
12 should have authority, report publicly on the nature and  
13 development of the programs and be given powers to assess the  
14 services.

15 THE CHAIRMAN: Mr. Major, I am sorry to have  
16 taken it away from you.

17 MR. MAJOR: I would like to go back to another  
18 couple of things. On page 3 on premiums. Would you consider  
19 that a fairly well-defined waiver of premium clause would be  
20 of assistance to the people you are considering here, paragraph  
21 12?

22 MR. BURT: I didn't catch the question.

23 MR. MAJOR: Would you consider a fairly well-  
24 defined waiver of premium clause, you know what I mean in  
25 insurance premiums, would be of assistance to the people you are



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5 thing that would be positive and we can go on.  
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13 development of the programs and be given powers to assess the  
14 services.  
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16 taken it away from you.  
17 MR. MAJOR: I would like to go back to another  
18 couple of things. On page 3 on premium? Would you consider  
19 that a fairly well-defined waiver of premium clause would be  
20 of assistance to the people you are considering here, paragraph  
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22  
23 MR. BURT: I didn't catch the question.  
24 MR. MAJOR: Would you consider a fairly well-  
25 defined waiver of premium clause, you know what I mean in





1 worrying about under paragraph 12? You might even be asked  
2 to negotiate the terms of the clause.

3 DR. GOLDBERG: This is on the assumption that  
4 the legislation wouldn't accept our recommendation?

5 MR. MAJOR: I am leaving the compulsory program  
6 aside.

7 DR. GOLDBERG: Assuming there is some premium  
8 such as now exists in respect of the Ontario Hospital Plan a  
9 waiver premium for lay-off or illness, I suppose, might be  
10 a very good way of getting out of the problem.

11 MR. MAJOR: Thank you, sir. Down on page 12,  
12 paragraph 21 the first sentence:

13 "Expenses for physicians' services,  
14 "while important, obviously do not represent  
15 "the only potential threat to the living standards  
16 "of the people of this province".

17 I think we would all agree with that. Consider-  
18 ing a prudent approach to health care in this province, and  
19 considering that maybe, the Government in its wisdom would  
20 prefer to play the building block game to arrive at, sometime  
21 in the future, a total health service, on the basis of what you  
22 have stated here what would you think would be the first building  
23 block to start with?

24 DR. GOLDBERG: This was a very difficult question  
25 to wrestle with, Mr. Major. Obviously the cost of physician



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DR. GOLDBERG: This was a very difficult question

to wrestle with, Mr. Major. Obviously the cost of physician



1 services is important, but we assume that in developing a  
2 programme, if it is developed in terms of timing, in terms  
3 of saving of certain coverage first with a view to covering  
4 the whole thing later, you have to be very careful as to what  
5 effect you are going to have not including one phase. What  
6 we are really recommending, we like the total approach to  
7 the problem. In addition you should be considering preventive  
8 medicine. Whatever plan may be devised for physician services  
9 it is important to encourage this important field. I think  
10 the way the Act is written, the way the legislation is written  
11 is really going to be important. We prefer a total approach  
12 in the recommendation to the committee even though it may be  
13 recommended in terms of timing, to put certain things in before  
PE/rps 14 others. But, we recognize the physicians' services will come  
15 in very close to the beginning.

16 MR. MAJOR: In your equitable system of taxation,  
17 it is your opinion that to do this you would pass on the ability  
18 to pay, which is just a redistribution of income, a certain  
19 percentage of total income? Is this your idea in this?  
20 Is this an equitable system?

21 DR. GOLDBERG: It is aggressive taxation, yes.

22 MR. MAJOR: And you are not prepared to say now  
23 whether or not you feel it would be good business to conscript  
24 a purveyor of medical care, of health services, to achieve the  
25 objection in a bloc system?





services is important, but we assume that in developing a programme, if it is developed in terms of timing, in terms of saving of certain coverage that with a view to covering the whole thing later, you have to be very careful as to what effect you are going to have not including one phase. What we are really recommending, we like the total approach to the problem. In addition you should be considering preventive medicine. Whatever plan may be devised for physical services it is important to encourage this important field. I think the way the Act is written, the way the legislation is written it is really going to be important. We prefer a total approach in the recommendation to the committee even though it may be recommended in terms of timing, to put certain things in before others. But, we recognize the physical services will come in very close to the beginning.

MR. MAJOR: In your estimate of the system of taxation,

DR. GOLDBERG: It is a general taxation, not.

MR. MAJOR: And you are not prepared to say how



1 DR. GOLDBERG: I am not sure that that word is  
2 even appropriate.

3 MR. MAJOR: Mr. Burt, I realize that what I  
4 am drawing now is a picture of this. You either have to start  
5 on a whole health care or start with blocs and if you start  
6 on blocs, what will be the recommendations to the Government  
7 as to how they can make sure that this bloc is 100% effective?  
8 That is the objective. You never really get anything 100%.  
9 You have no idea of the costs of this care, but you are going  
10 to work on it? I do not think I have any other questions.

11 THE CHAIRMAN: Do any other members of the Enquiry  
12 have any questions?

13 DR. GALLOWAY: I have one or two very small  
14 ones. I think that this meeting has been extremely valuable,  
15 certainly to me, because when I read your brief I found it  
16 very confusing and I think one has to read it on the basis,  
17 as you stated, in which you prefer -- an ideal, but, if. And  
18 our problem has been where the "but, if" is supposed to come  
19 in these recommendations. The Chairman has suggested, or  
20 requested you to give us your ideas in regard to the ideal.  
21 Mr. Whitney has suggested you give the ideals in regard to the  
22 specifics and I think this is a tremendous job that you agreed  
23 to do.

24 Where it is, maybe, more practical to think of  
25 the "but, if", if the principle of Bill 163 is maintained, it would



DR. GOLDBERG: I am not sure that that word is

even appropriate.

MR. MAJOR: Mr. Gold, I realize that what I

am drawing now is a picture of this. You either have to start

on a whole health care or start with pieces and if you start

on pieces, what will be the recommendations to the Government

as to how they can make sure that this piece is 100% effective?

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THE CHAIRMAN: Do any other members of the Executive

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1 likely be the most valuable thing that you could give us and  
2 at the same time your own ideals. And if you have agreed to  
3 do this, I think you have taken on a job which must be  
4 fantastic. I wanted to clarify, sir, exactly what help it is  
5 this group are planning to do for us. I think you have  
6 asked them for too much, or we have not asked them for the  
7 things we really want.

8 DR. GOLDBERG: I take it that the request today  
9 is in terms of our proposal, for what we consider a proper  
10 health care program for the people of Ontario, to be specific  
11 as to what would constitute such a program. I think that is  
12 what the Chairman asked us to do, in more specific terms than  
13 we have done, and also to make a study, as close as we are  
14 capable of making at the time, of whether additional revenues  
15 would be required and to what extent, and so on, and really  
16 spell out what we consider a proper health program for the  
17 people of Ontario. That is what we have undertaken to do.

18 DR. GALLOWAY: And this would be practically  
19 a redrafting of the Bill, because Bill 163 is inadequate and  
20 should be scrapped?

21 MR. WHITNEY: I might suggest to you that other  
22 briefs have suggested a redrafting of certain Sections of the  
23 Bill; so you can feel free if you do not really understand  
24 Section 12 -- and I think I would be naive to accept that  
25 statement. I am sure you understand something about Section 12,



1 I think the fact that the Government has decided to do this  
2 and the fact that the Government has decided to do this  
3 is a very important one. I think the Government has decided to do this  
4 and the fact that the Government has decided to do this

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6 asked them for too much, or we have not asked them for the  
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17 people of Ontario. That is what we have undertaken to do.  
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19 a redefining of the Bill, because Bill 102 is inadequate and  
20 should be scrapped?

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22 people have suggested a redefining of certain sections of the  
23 Bill; so you can feel free if you do not really understand  
24 Section 12 -- and I think I would be naive to accept that



1 but you see some vagueness about it, probably.

2 Go on Section 12 and give us a redraft of it.

3 We would be like to consider it.

4 DR. GOLBERG: What we are primarily concerned  
5 with, as I say, is to meet your request to be more specific  
6 on what we are recommending for the people of Ontario, in  
7 detail, with estimates of costs so far as we are able to do  
8 and that we will certainly prepare for the Committee and present  
9 to you.

10 DR. GALLOWAY: I am trying to clarify this  
11 point. This, really, is outside of Bill 163 and any discussion  
12 related to Bill 163, other than to say it is inadequate, because  
13 the principles you are suggesting is the entire opposite of  
14 this Bill. There is only one thing that is comparable about  
15 it and that is prepayment. But, on the one hand, it is pre-  
16 payment by Government, and, on the other hand, it is by voluntary  
17 organizations. This is what I want to make clear, what you  
18 are planning to do.

19 DR. GOLDBERG: I think that is what we have  
20 been asked to do.

21 DR. GALLOWAY: And if we, as a Committee -- and  
22 I can assure you, there have been no meetings about what decisions  
23 we are going to make on any point -- decide on retaining the  
24 principle of Bill 163, then it may be that the amount of work  
25 that you are going to do is going to be of little value, other



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I can assure you, there have been no meetings about what decision

we are going to make on any point -- definite -- on retaining the

principle of Bill 163, then it may be that the amount of work

what you are going to do is going to be of little value, other



1 than for some isolated points that may come out of it.

2 If you are prepared to do this tremendous job we, of course,  
3 would be very happy to see it.

4 MR. CASWELL: I think that the information that  
5 will be most valuable -- and it may be that he can't recommend  
6 or accept it all, this is true, at this time -- but I think  
7 that our recommendations to the Government are going to have  
8 to not only carry recommendations of what we suggest today,  
9 but what we will be suggesting for the future and with this  
10 kind of information we could make a far better recommendation  
11 as to how this service should be introduced and how it should  
12 be projected in the future. I think we need this information  
13 if these gentlemen are willing to give it to us.

14 THE CHAIRMAN: I have a statement that I would  
15 like to make at the end of this. However, before that do any  
16 other members of the Enquiry have any questions or anything  
17 to add to this? If so, I would like you to do so first.

18 DR. GALLOWAY: I would like to clarify one small  
19 point. I am concerned that the group who are with us today  
20 are keen that the consumer take part in the negotiation of  
21 medical fees. Does this indicate that at the moment you are  
22 dissatisfied with the fee schedule?

23 DR. GOLDBERG: No.

24 DR. GALLOWAY: Or that you will be in the future?

25 DR. GOLBERG: The manner in which they are revised,



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25. DR. GOLDBERG: The manner in which they are revised





1 or any specific fee?

2 DR. GALLOWAY: I am interested in as at this  
3 time. Do you have any objections to the Ontario Medical  
4 Association fees schedule which they have, over the years,  
5 built up, so that in the future you won't be able to have some  
6 say in whether or not they should be revised?

7 MR. BURT: I would say regardless of whether or  
8 not we would consider the present fee schedules adequate or  
9 inadequate or exorbitant, or what-have-you, we feel that, at  
10 least, the consumer should be given an opportunity to voice his  
11 views about it.

12 I know the present service plan, the fees are  
13 raised. We do not know why. I guess the doctors need more  
14 money. I can't live on what they are getting, or something  
15 is wrong. We do not know why they are raised and we have tried,  
16 as an organization, to obtain representation on these service  
17 plans.

18 DR. GALLOWAY: I think you have maybe put your  
19 figure on a point.

20 MR. BURT: And we have been unable to do so.  
21 But we think that in this case they should be subject to a  
22 little bit of public scrutiny.

23 DR. GALLOWAY: If we carried this thing right  
24 down to the end, what you want is consumer representation on  
25 negotiations of any cost?



or any specific fees?

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built up, so that in the future you won't be able to have some

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raised. We do not know why. I guess the board has

money. I can't live on what they are getting, on something

is wrong. We do not know why they are raised and we have tried

as an organization to obtain representation on these services

DR. GALLOWAY: I think you have maybe put your

figure on a point.

MR. BUNT: And we have been unable to do so.

But we think that in this case they should be subject to a

little bit of public scrutiny.

DR. GALLOWAY: If we carried this thing right

down to the end, what you want is consumer representation on

negotiations of any costs?



1 MR. BURT: Yes. I do not think it is based  
2 on the fact that the present schedule may be too high or not  
3 enough.

4 DR. GALLOWAY: Would you be willing to have  
5 these consumers present at your negotiations?

6 MR. BURT: We have a consumer present at our  
7 negotiations. He is not there in person, but he is there all  
8 right and we have breaks on us. And don't forget that our  
9 whole operation is generally subject to public scrutiny, is  
10 well-reported in the press and because we have to go through  
11 Government conciliation.

12 If the medical association had to go through  
13 what the labour movement does, that would be almost satisfactory,  
14 I believe, to us. Then you could strike after that.

15 DR. GALLOWAY: I was going to ask if that was  
16 the next step.

17 DR. BUTT: You are recommending it, then?  
18 This is what you are recommending?

19 MR. BURT: That is right.

20 THE CHAIRMAN: A negotiated fee structure?

21 MR. BURT: Yes.

22 MR. MAJOR: Can I clarify one point. The operations  
23 of the service plan similar to P.S.I. are under very strict  
24 scrutiny by others. All the subscription rates set by an  
25 organization such as P.S.I. -- and it involves possibly 50 of them





MR. BURN: Yes. I do not think it is based

on the fact that the present schedule may be too high or not

DR. GALLAGHER: Would you be willing to have

MR. BURN: We have a common message at our

negotiations. He is not there in person, but he is there all

right and we have friends on us. And don't forget, our

whole operation is generally subject to public scrutiny, is

well-reported in the press and because we have to go through

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what the labour movement does, that would be almost satisfactory

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DR. GALLAGHER: I was going to ask if that was

the next step.

DR. BURN: You are recommending it, then?

This is what you are recommending?

MR. BURN: That is right.

THE CHAIRMAN: A suggested two alternatives

MR. BURN: Yes.

MR. MAJOR: Can I clarify one point. The operation

of the service plan starts to 1945 and under very strict

scrutiny by others. All the expenditure is set by an

organization such as P.S.I. -- and it involves possibly 50 of the



1 throughout this province -- must satisfy the Government, through  
2 the Superintendent of Insurance, that the rates are equitable  
3 in relation to the business included. This is a very fine  
4 control which is not put on any other organization that I know  
5 of.

6 There is also the fact that the Superintendent  
7 of Insurance has, in the past, been able to call the shots on  
8 subscription rates of these organizations to such an extent  
9 that he has left the organization shy of funds.

10 Just how much control do you really want from  
11 the public? Here is a very potent control, handled by the  
12 Province of Ontario itself.

13 MR. BURT: I do not think that is public control,  
14 as such. I certainly haven't seen an explanation from this  
15 Government official as to why he agreed all the time with the  
16 increase in rates, because he has been in the service plan and  
17 as I understand it any shortages that the service plan would have  
18 have been made up the following year by an increase in fees,  
19 from what I understand.

20 MR. MAJOR: You are getting into some details.

21 MR. BURT: There is no public hearings.

22 MR. MAJOR: The United Automobile Workers and  
23 the Canadian Labour Congress and various others, they have had  
24 their sessions with the Superintendent of Insurance over these  
25 points?



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the Canadian Labour Congress and various others, they have had  
their sessions with the Superintendent of Insurance over these





1 MR. BURT: That is not the same as a public  
2 hearing. We haven't had, as far as we are concerned, a public  
3 hearing.

4 MR. MAJOR: That is all, thank you.

5 THE CHAIRMAN: Are there any further questions?  
6 Gentlemen, I would like to draw your attention to paragraph 3  
7 of the statement that was given to you at the beginning here,  
8 which reads:

9 "It is not our intention to debate

10 "your suggestions or recommendations, nor to

11 "state the views of this Enquiry on them."

12 It seems to me that the way your brief is  
13 worded you have come here with an expectation that these things  
14 that you have criticized were going to be discussed and, possibly,  
15 debated back and forth because most of the -- or, many -- I  
16 shouldn't say most -- but many of the statements in here are  
17 critical, without being constructively critical. In other  
18 words, I mean you have criticized a situation which either  
19 exists within your interpretation of the Act as it is set up  
20 here now, or what might result if this Act came into being,  
21 without suggesting a way in which the situation of which you  
22 are critical may be improved or corrected, other than the  
23 complete universal plan.

24 Now, some of the statements in here, I hope you  
25 will appreciate that the members of the Enquiry disagree -- in



MR. BURET: That is not the same as a public

ring. We haven't had, as far as we are concerned, a public

MR. MAJOR: That is all, thank you.

THE CHAIRMAN: Are there any further questions?

Gentlemen, I would like to draw your attention to paragraph 3

of the statement that was given to you at the beginning here,

which reads:

"It is not our intention to debate

"your expectations or recommendations, nor to

"state the views of the majority on them."

It seems to me that the way your brief is

worded you have come here with an expectation that those things

that you have criticized were going to be discussed and, possibly

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are critical may be improved or corrected, other than the

complete universal plan.

Now, some of the statements in here, I hope you

will appreciate that the members of the majority disagree -- in



1 other words, our failure to comment on or to contradict any of  
2 these statements is not an indication that they meet with the  
3 approval of the members of the Enquiry here. I am hopeful that  
4 when we do not bring those things up, you understand that it  
5 is not an acceptance, although it could be an acceptance, and  
6 that we are not permitted to debate many of the things that I  
7 would thoroughly have enjoyed debating with you. This has been  
8 a policy with which the members of the Enquiry agreed from the  
9 beginning.

10 Is there a further statement?

11 MR. BURT: If you examine carefully our 15  
12 points and recommendations and summary and our main conclusions,  
13 we intended to read them to you, but you dealt with those  
14 15 points, I believe, exhaustively. And I would like to point  
15 out that we do make constructive recommendations for things  
16 that are now included in the Bill. You can hardly make a  
17 recommendation about things that are not included in the Bill.  
18 And we were also restricted, as I suggest you are by your  
19 own terms of reference, because they handed you an Act that  
20 was already drafted and they said "Here is your terms of refer-  
21 ence", as I understand it, and you are rather confined to  
22 them.

23 Now, when we made what was termed here as negative  
24 suggestions in our criticism -- negative criticisms -- we were  
25 dealing with things and pointing out things which were not included





other words, our failure to comment on or to contradict any of  
these statements is not an indication that they meet with the  
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Now, when we made what was termed here as negative  
statements in our Bill, we were not  
dealing with things and pointing out things which were not incl



1 in the Bill. However, we do deal with a number of instances  
2 in our 15 proposals with specific recommendations, starting  
3 off with recommendation No. 1, and we recommend that legis-  
4 lation be amended to encompass the whole range of services,  
5 and we go on with that recommendation.

6 Then we deal with another recommendation in 6.  
7 We deal with one in No. 7 and all throughout. We even deal  
8 with one which we do not agree with in respect to the manner  
9 in which the Bill is to be financed, and if you are going  
10 to stick to this, you are going to do it in a certain way.  
11 We do not know how else to make that . . .

12 THE CHAIRMAN: I think . . .

13 MR. BURT: Just a moment. I will be finished  
14 in a moment, sir. We also have a specific recommendation in  
15 No. 11, 12 and 13 and 10 and in No. 15. And I do not know  
16 how it can be construed that we have simply indulged in some  
17 negative criticism of the Bill, when we make specific recommend-  
18 ations of how we think it should operate.

19 THE CHAIRMAN: Would you grant me this, that  
20 I said many of the statements -- I didn't say that you didn't  
21 make any constructive statements -- I said many of the state-  
22 ments were critical?

23 MR. BURT: You didn't say, sir, that we also  
24 included many recommendations.

25 THE CHAIRMAN: That is right, granted.

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with one which we do not agree with in respect to the manner  
in which the Bill is to be financed, and if you are going  
to stick to this, you are going to do it in a certain way.

We do not now have to make that . . .

THE CHAIRMAN: I think . . .

MR. BENT: I am a member. I will be finished

in a moment, sir. We also have a specific recommendation in  
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ments were critical?

MR. BENT: You didn't say, sir, that we also

included many recommendations.

THE CHAIRMAN: That is right, granted.





1 MR. BURT: Yes. I suppose we are about to  
2 conclude and I would like to take this opportunity of thanking  
3 the Committee for a very courteous and fair hearing that we  
4 have received at your hands this morning, Mr. Chairman, and  
5 also to say that we will supply the material that you have  
6 requested and which we have agreed to supply, to the best  
7 of our ability.

8 We understand that the last hearing is going to  
9 be -- that you are going to hear the Medical Association and  
10 we were wondering if we would be permitted after that hearing  
11 takes place to have a rebuttal?

12 THE CHAIRMAN: You can request it, but there  
13 has been no decision made on this and I cannot give you an  
14 answer at the present time.

15 MR. WHITNEY: May I correct one or two or the  
16 premises which Mr. Burt has stated. It might give a wrong  
17 impression. First of all, we have not been handed a Bill which  
18 must stand as it is.

19 MR. BURT: I understand that.

20 MR. WHITNEY: Your wording, though, is that  
21 we have been handed a Bill and it has placed some restriction  
22 on it. It really hasn't. The Government stands on a certain  
23 principle. This is true. But the Bill is subject to amendments  
24 in its present form, but additions or deletions.

25 Now, on your second point, you are quite free to



MR. HUNT: Yes. I suppose we are about to

conclude and I would like to take this opportunity of thanking  
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we have been handed a Bill and it has placed some restriction  
on it. It really hasn't. The Government stands on a certain

Now, on your second point, you are quite free to



1 make recommendations on something not is not in the Bill now.

2 MR. BURT: Yes. We have done that.

3 MR. WHITNEY: I want you to understand that

4 because it is going to affect the work you are going to do.

5 The Bill is not to be taken that it has to rest the way it is,

6 necessarily. You understand that?

7 MR. BURT: Yes.

8 MR. WHITNEY: And if there is something not

9 in this Bill, you are quite free to make a recommendation on

10 it. Your statement is incorrect in the fashion that you made

11 it. You said that you felt that you were not in a position

12 to make recommendations on things that were not in the Bill,

13 or something along that line. There is no limitation on you.

14 You can suggest amendments to the Bill even to the point of

15 drafting suggesting amendments, or you can suggest additional

16 clauses to this Bill and submit them to this Enquiry.

17 I want that clear so that you will be off on the  
18 right premise when you begin to make further specific recommend-  
19 ations here, if you wish to file them with us.

20 THE CHAIRMAN: Thank you very much, gentlemen.

21

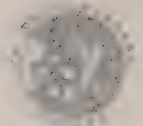
22 ---A short recess.

23

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1. The Bill is not to be taken that it has to rest the way it is.

2. MR. BURN: Yes. We have done that.

3. MR. WHITNEY: I want you to understand that

4. because it is going to be taken that way you have to be sure

5. The Bill is not to be taken that it has to rest the way it is.

6. The Bill is not to be taken that it has to rest the way it is.

7. MR. BURN: Yes.

8. MR. WHITNEY: And if there is something not

9. in the Bill, you can say that it is not to be taken that way.

10. The Bill is not to be taken that it has to rest the way it is.

11. The Bill is not to be taken that it has to rest the way it is.

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18. The Bill is not to be taken that it has to rest the way it is.

19. The Bill is not to be taken that it has to rest the way it is.

20. THE CHAIRMAN: Thank you very much, gentlemen.

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MR/RPS 1

SUBMISSION OF ONTARIO CHIROPRACTIC ASSOCIATION

2                                   Appearances: Mr. L.E. MacDougall  
3   Mr. C.A. Greenshields  
4   Mr. H.W.R. Beasley  
5   Mr. D.C. Sutherland  
6   Mr. R.J. Watkins  
7   Mr. R.K. Partlow

8                                   THE CHAIRMAN: Ladies and gentlemen, in  
9 conversation I guess it was with Mr. Sutherland -- is that  
10 right?

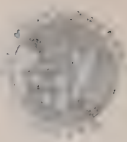
11                                  MR. SUTHERLAND: Yes sir.

12                                  THE CHAIRMAN: It was decided that we would  
13 carry on until one o'clock. If we are not finished with the  
14 hearing then, we would adjourn for about an hour and a quarter  
15 and reconvene then afterwards. Mr. Sutherland would you  
16 introduce your members? Have you had an opportunity to read  
17 the instructions that were placed on the table?

18                                  MR. SUTHERLAND: Yes sir. Our president,  
19 Mr. Lloyd MacDougall, will introduce the delegates.

20                                  THE CHAIRMAN: If you would introduce, as the  
21 press has requested, that you introduce and give their  
22 initials, and so forth so that they can pick them up ---

23                                  MR. MacDOUGALL: Mr. Chairman, as president of  
24 the Committee, I have been asked to act as spokesman for the  
25 Ontario Chiropractic Association today. My name is Lloyd E.  
MacDougall. I am president of the Ontario Chiropractic Assoc-  
iation. I have been a practising chiropractor in Oakville, Ontario.



PROCEEDINGS OF THE ANNUAL MEETING OF THE ONTARIO CHIROPRACTIC ASSOCIATION

- Appointees: Mr. L.E. MacDougall  
Mr. C.A. Greenhalgh  
Mr. E.W.R. Beasley  
Mr. J. J. MacDougall  
Mr. R.J. MacDougall

THE CHAIRMAN: Ladies and Gentlemen, in

the morning of the 1st of January, 1911, the Association met in the

MR. SUTHERLAND: Yes sir.

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carry on until one o'clock. If we are not finished with the

hearing then, we would adjourn for about an hour and a quarter

and reconvene then afterwards. Mr. Sutherland would you

introduce your members? Have you had an opportunity to read

the instructions that were placed on the table?

MR. SUTHERLAND: Yes sir. Our president,

Mr. Lloyd MacDougall, will introduce the delegates.

THE CHAIRMAN: If you would introduce, as the

Association has decided that the meeting should be held in the

morning, and as the Association has decided that the meeting

MR. MacDougall: Mr. Chairman, as president of

the Committee, I have been asked to act as spokesman for the

Ontario Chiropractic Association today. My name is Lloyd E.

MacDougall. I am president of the Ontario Chiropractic Assoc-

iation. I have been a member of the Association for many years.





1 and have maintained an office for 13 years.

2 Mr. Chairman I will now introduce our delegates.

3 Moving along the table to my left, H.W. Beasley, a practising  
4 chiropractor, chairman of the Board of Directors of  
5 Chiropractic, our Government-appointed licensing body. C.A.  
6 Greenshields, a practising chiropractor who has served for  
7 several years as chairman of the Board of Management of the  
8 Canadian Memorial Chiropractic College. Mr. D.C. Sutherland,  
9 executive-secretary of the Ontario Chiropractic Association.  
10 R.J. Watkins, clinical director of the Canadian Memorial  
11 Chiropractic College, a certified chiropractic roentgenologist,  
12 and past-president of the National Council of Chiropractic  
13 Roentgenologists. R.K. Partlow, practising chiropractor  
14 and past director of the Canadian Memorial Chiropractic College  
15 and past-president of the Ontario Chiropractic Association  
16 and currently president of the Canadian Chiropractic Association.

17 Mr. Chairman, we would like to thank your  
18 Committee for the privilege of appearing here today.

19 THE CHAIRMAN: If you would care to be seated,  
20 it is quite in order for you to do so.

21 MR. MacDOUGALL: I just have a couple more  
22 lines. I will stand. We would like to thank your Committee  
23 for the privilege of appearing here today and to express our  
24 professional views on Bill 163. We have followed with interest  
25 the hearings to date and we realize the magnitude of the task



Mr. Chairman I will now introduce our delegates.

Moving along the table to my left, H.W. Bessley, a practicing

chiropractor, chairman of the Board of Directors of

Chiropractic, our Government-appointed licensing body, C.A.

Greenhalgh, a practicing chiropractor who has served for

several years as chairman of the Board of Management of the

Canadian Memorial Chiropractic College, Mr. D.C. Rutherford,

executive-secretary of the Ontario Chiropractic Association.

R.J. Watkins, clinical director of the Canadian Memorial

Chiropractic College, a certified chiropractor and roentgenologist,

and past-president of the National Council of Chiropractic

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and past director of the Canadian Memorial Chiropractic College

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Committee for the privilege of appearing here today.

THE CHAIRMAN: If you would care to be seated.

It is quite in order for you to do so.

MR. MACDONALD: I just have a couple more

times. I will stand. We would like to thank your Committee

for the privilege of appearing here today and to express our

appreciation to the members of the Association.

The Association will now adjourn.



1 facing your Committee. The Chiropractic profession in Ontario  
2 will assist your Committee sir in any way and every way possible.  
3 We are willing to co-operate with all groups in the healing  
4 professions in the establishment of the best possible health  
5 insurance for the people of the Province of Ontario.

6 Our executive-secretary will now read from the  
7 summary in our brief.

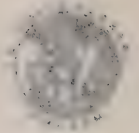
8 MR. SUTHERLAND: Mr. Chairman, members of the  
9 Committee, this brief is submitted by the Ontario Chiropractic  
10 Association, a provincial division of the Canadian Chiropractic  
11 Association, to inform the Medical Services Insurance Committee  
12 of the position, services and views of the chiropractic profession  
13 relating to Bill 163, an Act respecting medical services  
14 insurance.

15 THE CHAIRMAN: I assure you the members of the  
16 Enquiry have read and studied this, if you were intending --  
17 this is some five or six pages -- to read all of this. I can  
18 assure you this has been read by all of the members of the  
19 Committee here and it is not necessary for you to do that,  
20 by any means.

21 MR. SUTHERLAND: We do not intend to read the  
22 regulations, Mr. Chairman, but if you would prefer that we  
23 simply read our concluding statement ---

24 THE CHAIRMAN: I think you will find that the  
25 members of the Enquiry have prepared questions to ask you, and





1. The Commission has been established in Ontario  
2. will assist the Commission in its work and carry out its  
3. we are willing to co-operate with all groups in the building  
4. relationship in the establishment of the first Ontario health  
5. insurance for the people of the Province of Ontario.  
6. Our executive-secretary will now read from the  
7. summary in our brief.

8. MR. SUTHERLAND: Mr. Chairman, members of the  
9. Commission. This brief is submitted to the Ontario Legislative  
10. Assembly, a provincial division of the Canadian Confederation  
11. Association. To inform the public of the Commission's findings  
12. of the situation, various and other of the Commission's program  
13. relating to health, and the Commission's findings.

14. Insurance.  
15. THE CHAIRMAN: I assume you the members of the  
16. Legislative Council and the public, as you were interested in  
17. this is some time on the subject. In fact all of you. I am  
18. sure you have been told of all the members of the  
19. Commission and its work. I am sure you are all interested  
20. by any means.

21. MR. SUTHERLAND: We do not intend to read the  
22. Commission's report, but it is very interesting and  
23. simply read our Commission's findings.  
24. THE CHAIRMAN: I think you will find that the  
25. members of the Legislative Council and the public, as you were



1 probably the time could be better spent on answering the  
2 questions than reading what they have studied. That is what  
3 I was going to say.

4 MR. SUTHERLAND: In order to expedite the  
5 hearing, we can dispense with this reading, if you wish sir.

6 THE CHAIRMAN: If there are any general state-  
7 ments, however, that you would like to make, why do not  
8 hesitate to do so. Otherwise, we will proceed with the  
9 questioning.

10 MR. SUTHERLAND: Our principal stand, of course,  
11 Mr. Chairman, is that Bill 163 should be amended to provide  
12 for the inclusion of the services of qualified, licensed  
13 chiropractors to serve the people of Ontario through this  
14 legislation.

15 THE CHAIRMAN: All right. Then I will call  
16 on some of the members of the Enquiry here who have indicated  
17 their wish to ask some questions. Miss McArthur?

18 MISS McARTHUR: Thank you Mr. Chairman. I can  
19 assure the delegates that this brief made me work, and to get  
20 through the brief and to attempt to understand it did take some  
21 time and so we are not doing this lightly.

22 I would like to first ask a question or two  
23 in relation to some of the recommendations, Recommendation 8  
24 being the first one:

25 "that treatment may be continued for as long



1 Probably the time could be better spent on answering the

2 question concerning the time taken by the committee.

3 I was going to say.

4 MR. SUTHERLAND: In order to expedite the

5 meeting, we can discuss this question in the next day.

6 THE CHAIRMAN: I think we will proceed with the

7 matter, however, first we shall discuss the time taken.

8 hesitate to do so. Otherwise, we will proceed with the

9 questioning.

10 MR. SUTHERLAND: Our principal stand, of course,

11 the Chairman, is that all the time should be spent on the

12 the time taken by the committee in the past.

13 the time taken by the committee in the past.

14 legislation.

15 THE CHAIRMAN: All right. Then I will call

16 on some of the members of the committee to answer the question.

17 their time taken in the past.

18 MISS MCARTHUR: Thank you Mr. Chairman. I can

19 answer the question which was put to me.

20 through the time taken by the committee in the past.

21 time and so we are not doing this lightly.

22 I would like to raise such a question on two

23 in relation to the time taken by the committee.

24 being the first one:

25 "that treatment may be continued for as long



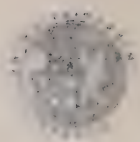


1 as may be deemed necessary in the opinion of the chiropractor."

2           Recognizing that many briefs have indicated  
3 that one needs, in all groups, to have some controls, I was  
4 wondering -- I did find some answers to the controls in relation  
5 to the utilization of services in recommendation 13 and 15,  
6 and I wondered whether you have considered those two recommend-  
7 ations sufficient to provide adequate controls in the utiliz-  
8 ation of service and in relation to making the basic consider-  
9 ations of each particular profession who give a particular  
10 service. I know, I am speaking from nursing knowledge mainly,  
11 and I know that we have nurses in our profession who have  
12 difficulty making decisions when it relates to the total field  
13 of medical care, and I would think that the doctors themselves  
14 might even indicate on occasion they have some difficulty in  
15 making the wisest decision.

16           This was one of the questions that came to my  
17 mind: Do you deem that 13 and 15 is all that is necessary to  
18 provide controls when you say the continuing service should  
19 be on the basis of the opinion of the chiropractor?

20           MR. GREENSHIELDS: Mr. Chairman, could we answer  
21 that by saying that these recommendations would add the nec-  
22 essary facets in with Bill 163 to those that are already restrict-  
23 ing and limiting and controlling our profession and by that  
24 we would refer you to the legislative section wherein we are  
25 controlled by Government-appointed boards under an Act and



1 to the extent that the evidence is not sufficient to establish the  
2 fact that many of the persons who have indicated  
3 that they are not satisfied with the service are not  
4 satisfied with the service in the same way as the persons who  
5 are satisfied with the service are satisfied with the service.  
6 and I wondered whether you have considered those two recommend-  
7 ations sufficient to provide adequate controls in the utiliz-  
8 ation of service and in relation to making the basic consider-  
9 ations of each particular profession who give a particular  
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12 difficulty with the service and I know that the doctors themselves  
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15 making the wisest decision.  
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17 mind: Do you deem that 13 and 15 is all that is necessary to  
18 provide controls when you say the continuing service should  
19 be on the basis of the opinion of the chiropractor?  
20 and I am assuming that the service should be on the basis  
21 of the opinion of the chiropractor and I am assuming that the  
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24 the opinion of the chiropractor and I am assuming that the service  
25 should be on the basis of the opinion of the chiropractor.



1 regulations and that to treat a patient that we know in our  
2 professional opinion, or that of our associates would not be  
3 in the best interests of that patient, would be professional  
4 misconduct. In addition to that, we are controlled to an  
5 extent by the Committee of Ethics and Discipline of our  
6 Ontario Association, which we have outlined here to you, as well  
7 as the obligation that is placed on the practitioner to  
8 consult with his fellow practitioner and to refer to other  
9 health practitioners where the response was not that which was  
10 anticipated or where other problems may develop. Taking this  
11 total control and limitation that is placed upon the individual  
12 and responsibility, we feel that these recommendations would  
13 protect the public interest.

14                   MISS McARTHUR: That clarifies that for me sir.  
15 In recommendation 15(c) I wondered if you had considered such  
16 a board of referees, looking at the composition, as relating  
17 to other groups as well who might very well seek similar  
18 provisions since you only have related the composition of your  
19 board of referees to the two chiropractors.

20                   MR. GREENSHIELDS: In drafting this recommend-  
21 ations we envisioned that perhaps each professional group would  
22 require this type of a board. In other words, there might be  
23 a medical board of referees for physicians to handle the  
24 particular problems that would come up with their practice and  
25 this is an outgrowth of our insurance adjudication committee whereon





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the best interests of the public...  
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a board of referees, looking at the composition, as relating

to other groups as well who might very well seek similar

board of referees to the two chiropractors.

MR. GREENBERG: In dealing this recommend-

a medical board of referees for physicians to handle the

practitioner problems that would come up with their patients and

this is an extension of our previous obligations and responsibilities



1 members of our profession have their problems talked about and  
2 discussed and solved between the insurance companies and  
3 our Association and it seems that those that are close to  
4 the problem have an insight into it and committees of this  
5 sort, or boards so set up could settle the small differences  
6 that are bound to arise in any plan.

7 MISS McARTHUR: Thank you. I think that answers  
8 my question. I was not too clear about recommendation 10.  
9 Were you just saying that a basic plan should be provided  
2 10 to citizens where they should be permitted to take over and  
11 above benefits, or did that have another implication?

12 MR. GREENSHIELDS: That any plan will not restrict  
13 a citizen who was seeking health care on a private patient  
14 basis.

15 MISS McARTHUR: This was not clarified. It was  
16 not quite clear to me.

17 MR. SUTHERLAND: It was one of the recommendations  
18 which we presented to the Royal Commission on Health Services  
19 and it perhaps had more application in their study than in  
20 this one. However, we did think that it should be left in  
21 because as we mentioned below, these recommendations are suit-  
22 able for the doctor-patient relationship envisaged under this  
23 Bill and could apply to all practitioners and covered persons.

24 MR. GREENSHIELDS: May I add one other thought  
25 to that? If a carrier has agreed to provide protection, that he



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our Association and it seems that those that are close to  
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MR. SUTHERLAND: It was one of the recommendations

which we presented to the Royal Commission on Health Services

and it perhaps had more application in their study than in

this one. However, we did think that it should be left in

the report as a recommendation for the future.

MISS McARTHUR: I am sorry, but I am not sure that I

am clear on this. I am not sure that I am clear on this.

MR. GREENSHIELDS: May I add one other thought

to what I have said. I am not sure that I am clear on this.





1 should not necessarily set out that you should have your health  
2 care by a certain physician or health practitioner by name of  
3 an individual but that you should have a choice. In other  
4 words, they are willing to cover the cost, or provide the  
5 service but not to stipulate the individual person that will  
6 render it to you.

7 MISS McARTHUR: You did not find anything in  
8 Bill 163 that said that such a thing might occur?

9 MR. GREENSHIELDS: That is right.

10 MISS McARTHUR: It was a question in your mind  
11 though?

12 MR. GREENSHIELDS: Yes.

13 THE CHAIRMAN: Do I understand that you go further  
14 with that paragraph? You mean not just the individual by name  
15 or individual identification, but by the type of practitioner  
16 as well?

17 MR. GREENSHIELDS: Correct.

18 MISS McARTHUR: I have two other questions that  
19 are rather small Mr. Chairman -- they are not small. Perhaps  
20 they have rather deep implications and it comes in your summary  
21 S15 and I was wondering if that statement implied that you felt  
22 that major contributions by chiropractors was in the area of  
23 spinal strains and sprains and if there was a question of  
24 consideration that this might be a limitation. Were you infer-  
25 ring that this might be a limitation?



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with that paragraph? You mean not that the individual by name or individual identification, but by the type of profession as well?

MR. GREENSHIELDS: Correct.

MISS McARTHUR: I have two other questions and

spinal strains and sprains and if there was a question of consideration that this might be a limitation. Were you inter-



1 MR. SUTHERLAND: No, we did not mean to imply  
2 that in this statement. We used these statistics simply because  
3 they are available and they happen to refer to spinal injuries.  
4 However, we feel that there is a broader application by our  
5 service than simply strains and sprain type of case. I  
6 believe we have covered further in the brief the scope of work  
7 of chiropractic care in that many, for example, symptoms that  
8 develop from nerve group irritation can imitate many conditions,  
9 angina perhaps, gall bladder disease.

10 MISS McARTHUR: I am at the top of the page and  
11 this is what I wondered, as I read it through. What I was  
12 wondering, as I tried to understand the evidence presented, was  
13 whether there could be an implication that you might see this  
14 particular service as having a limitation in time; that it  
15 might not always be an ancillary service indefinitely. I  
16 read Mr. Parsons of Red Deer. Being a great transplanted  
17 Albertan, naturally I found something from that province and  
18 it sounded very much like the west, if you cannot beat them,  
19 join them comment. I was just wondering if you did see that  
20 there were facets in your practice that might well be accepted  
21 by the medical profession which in time might limit the  
22 practice of chiropractic.

23 MR. WATKINS: This commentary could well be  
24 followed through the trend of a number of these exhibits in  
25 that over the years, in the past few anyhow, there has been an







1 increasing awareness of the relationship between neurological  
2 syndromes and body mechanics. There has even been an increase  
3 in the number of physiatrists, of physical medicine and in many  
4 instances it would appear that the medical profession has  
5 finally re-awakened to an area which has been neglected for a  
6 long time and which now are following the chiropractic leads  
7 in evaluating this material. It is definitely a closer  
8 amalgamation all the way through, and it would appear on that  
9 basis the two can work very well together, with body mechanics  
10 and chemo-therapy working hand in hand as has been done  
11 unofficially in many, many instances so that the chiropractors  
12 are, in essence, just defining their position as that of body  
13 mechanics in contrast to chemo-therapy and we are, as a  
14 result, becoming specialists in body mechanics but not necessar-  
15 ily confining the whole thing to strains and sprains.

16 MISS McARTHUR: To follow that up, there has  
17 been a gradual change in the curriculum of preparation because  
18 of the change or is this just leading to this kind of a point  
19 now?

20 MR. WATKINS: There has been a change of curriculum,  
21 a re-emphasis of both the medical schools and chiropractic  
22 college in that there has been an increased emphasis on physical  
23 medicine in some of the med. schools and there has been a deeper  
24 understanding of some of the basic sciences in the chiropractic  
25 college over what used to be done.



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1                   MISS McARTHUR: Thank you sir. I had questions  
2 that were in my mind, and I referred to them.

3                   THE CHAIRMAN: Mr. Caswell?

4                   MR. CASWELL: Well Mr. Chairman, there are a  
5 number of things I want to say. You could point out that the  
6 Government, through the Workmen's Compensation Board recognizes  
7 chiropractic services. However, is this not on strictly a  
PB/RPS 8 referral basis?

9                   MR. MacDOUGALL: No, sir. The workman has  
10 free choice himself.

11                  MR. CASWELL: You have some carriers who are  
12 covering chiropractic. Is that on a free choice or through  
13 referral?

14                  MR. MacDOUGALL: Free choice, sir, in most  
15 cases.

16                  THE CHAIRMAN: Dr. Hamilton?

17                  DR. HAMILTON: I am not quite clear on what is  
18 the scope of chiropractic. The statement was made it goes  
19 beyond sprains and you mentioned symptoms arising in the spinal  
20 column that might simulate organic disease elsewhere.

21                  MR. WATKINS: This was brought out in some of  
22 the evidence in the presentation of Dr. Goldthwait in Boston  
23 who talking of body mechanics has pointed out several cases of  
24 appearances of organic heart disease where repeated cartiograms  
25 established there was no organic disease. The condition was



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MR. WARDEN: This was brought out in some of

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who talking of body mechanics has pointed out several cases of



1 caused by pressure on or pinching of the nerves at the  
2 foramina of exit. These were appreciably relieved by mechanics.  
3 In some cases it was just improving posture; in other cases  
4 by specific adjustment and manipulating. (Others in the  
5 same book were related to the appearance of symptoms of chronic  
6 appendicitis which were proven to be a neurological  
7 problem, an irritation at the spinal column.) These were  
8 specific examples of the simulation of organic disease.

9 DR. HAMILTON: How do you know the difference  
10 when the symptoms arise from disturbances in the spinal column?

11 MR. WATKINS: This was pointed out by Goldthwait  
12 in a group of researches with Alvertz of Mayo Clinic on  
13 appendicitis. About 225 cases had been operated on, and of  
14 the 225 there was about two per cent which had complete  
15 recovery.

16 DR. HAMILTON: You didn't answer the question,  
17 how does the chiropractor know. I asked a specific question.

18 MR. WATKINS: The chiropractor's evaluation is  
19 based on physical examinations as is everyone else in the  
20 health profession, but with special emphasis upon spinal  
21 examination. If there is a definite evidence of inflammation of  
22 the appendix with elevated white count, fever et cetera it may  
23 very well be inflammation of the appendix. If there is no spinal  
24 irregularity -- this is pathology. If there is a marked spinal  
25 irregularity which could contribute to it and if in a couple of days





1. ... of ...

2. ... of ...

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4. by specific adjustment and manipulating. (Others in the

5. ... of ...

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24. irregularity -- this is pathology. If there is a marked spinal

25. ... of ...



1 the symptoms subside we assume it is a neurological  
2 problem.

3 DR. HAMILTON: You mean the spinal irregularity  
4 could develop in inflammation of the appendix. Is this what you  
5 mean?

6 MR. WATKINS: The symptoms of that as pointed  
7 out by Goldthwait on this topic of body mechanics -- you were  
8 asking how we would evaluate the difference. If there is a  
9 definite deviation of spinal alignment and all the symptoms of  
10 nerve roots we would make that correction. We would assume  
11 that was the problem.

12 DR. HAMILTON: If the symptoms didn't subside?

13 MR. WATKINS: Then we would refer them to you.

14 DR. HAMILTON: After an interval, this you said  
15 is after an interval.

16 MR. WATKINS: If, however, the spinal symptoms were  
17 not determined we would send them to you immediately.

18 DR. HAMILTON: I am interested in the scope  
19 of chiropractic in areas of disease that are not amenable to  
20 treatment by your method. What are these?

21 MR. WATKINS: There are many cases that would  
22 fall into that category. For example there are obviously  
23 tumors that require medical care. There are many fungus  
24 infections which would obviously be within the category of  
25 chemo-therapy rather than chiropractic.



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1. The first question is whether or not the patient has a problem.

2. Problem.

3. DR. HAMILTON: You mean the spinal irregularity

4. which is the cause of the symptoms? Or is it the result of

5. means?

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7. out by Goldswait on this topic of body mechanics -- you were

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25. chemo-therapy rather than chiropractic.





1 There are many infections that are outside the scope of chiro-  
2 practic.

3 DR. HAMILTON: Are there any others?

4 MR. WATKINS: Oh yes. But at the moment rather  
5 than go on in detail we can say that is the reason that the  
6 chiropractor does include physical examinations, does them  
7 very closely parallel to the medical practitioner.

8 DR. HAMILTON: Does the curriculum include  
9 training students in the recognition of those diseases that  
10 are not the results of disturbances in the spinal column?

11 MR. WATKINS: Yes, fractures and dislocations,  
12 for example.

13 DR. HAMILTON: That would be fairly obvious.

14 MR. WATKINS: Right.

15 DR. HAMILTON: To come back to these conditions  
16 you mentioned before that you say are not within the scope of  
17 chiropractic, such as tumors, appendicitis, that is not the  
18 result of disturbances of the spinal column?

19 MR. WATKINS: I think you will find the  
20 curriculum outlined in one of the exhibits including courses  
21 in dermatology, digestive problems and so on.

22 DR. HAMILTON: My concern, and I am sorry if I  
23 appear to be very persistent, but my question is how do your  
24 students learn to recognize these disorders that are not  
25 amenable to your method of treatment? Many people will come to



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in dermatology, digestive problems and so on.

DR. HAMILTON: My concern, and I am sorry if I



1 a chiropractor or a physician or anybody else for health care  
2 without having any idea of what is wrong.

3 MR. MacDOUGALL: In answering that the different-  
4 ial diagnosis establishes those cases that are chiropractic  
5 cases or we feel would be amenable to chiropractic. In the  
6 study of pathology it is necessary to go back to the situation  
7 behind the cause of this condition and to discover if they are  
8 conditions not in the chiropractic field. It is not the  
9 evaluation of the patient as he presents himself but knowing  
10 the background. I am sure you have in your mind . . .

11 DR. HAMILTON: I am interested in knowing how  
12 the practitioner of chiropractic reaches the diagnosis. In  
13 many diseases or conditions, in those you have already indicated  
14 that are not amenable to this method of treatment, what is  
15 the background that enables him to make the diagnosis?  
16 What is his training?

17 MR. MacDOUGALL: His training in diagnosis,  
18 training in pathology, chemo-therapy, his clinical experience  
19 in clinics while still in practice and in college, in his  
20 college years.

21 DR. HAMILTON: He then is exposed to patients  
22 with these disorders?

23 MR. MacDOUGALL: Yes, the clinic at the college  
24 has many cases which are presented that are not chiropractic  
25 cases and which are referred to medical practitioners. The





without having any idea of what is wrong.

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cases and which are referred to medical practitioners. The



1 clinic director, Dr. Watkins and the staff evaluate these and  
2 refer them. In some cases it is necessary for them to send  
3 them for surgical and medical and specialist opinion to arrive  
4 at the total situation just the same as your field. It is  
5 necessary for us to refer them.

6 DR. HAMILTON: Would you tell me what means of  
7 diagnosis are at your disposal?

8 MR. MacDOUGALL: The diagnostic procedures  
9 that are common to all in the medical field of X-ray and blood  
10 pressure and heart examinations, urinalysis and blood tests  
11 and so on down the line.

12 MR. WATKINS: Perhaps a specific example of that  
13 would be what you would like. (We had a patient very recently  
14 which shewed some blood in the urine. Laboratory examination  
15 showed by pus, no tissue cells.) We referred his to a urologist  
16 who found he had a cyst, discovered a small tumor breaking down.  
17 That patient is having that removed today. That is one we  
18 discovered which wasn't within our realm and he is being  
19 handled by a competent surgeon.

20 DR. HAMILTON: Those conditions that are  
21 amenable to treatment the excerpt of Medicine and Chiro-  
22 practic which is a little book included with the brief covers,  
23 perhaps, more of that than we can cover here today very  
24 thoroughly. After investigation of a group of medical doctors  
25 who were looking into chiropractic they pointed out that they are



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MR. WATKINS: Perhaps a specific example of that

would be what you would like. (We had a patient very recently

which showed some blood in the urine. Laboratory examination

discovered which wasn't within our realm and he is being

handled by a competent surgeon.

DR. HAMILTON: Those conditions that are

amenable to treatment the except of Medicine and Gyneco-

practic which is a little book included with the brief covers,

perhaps, more of that than we can cover here today very





1 able to lower blood pressure 30 millimetres with one adjustment.

2 DR. HAMILTON: Would you say that again? You're

2 3 able to lower blood pressure?

4 MR. WATKINS: About 30 millimetres with one  
5 adjustment which was pointed out here by some medical doctors  
6 in this little book Medicine and Chiropractic which you have  
7 in your exhibits. That was a statement of medical doctors  
8 that were investigating chiropractic care. There are many  
9 others there that are covering some of the fringe areas which  
10 you are apparently questioning.

11 DR. HAMILTON: Yes, I am questioning the fringe  
12 areas, very frankly. Do you treat individuals with high  
13 blood pressure?

14 MR. WATKINS: We have had many people coming in  
15 with high blood pressure who showed excellent improvement very  
16 rapidly and some others who did have organic backgrounds that  
17 required medical care. It was a matter of making a diagnosis.

18 DR. HAMILTON: Thank you Mr. Chairman.

19 THE CHAIRMAN: Mr. Major?

20 MR. MAJOR: Thank you, Mr. Chairman. I have  
21 a couple of questions for clarification. Recommendation 8  
22 "that treatment may be continued for as long as may be deemed  
23 necessary in the opinion of the chiropractor". Some place  
24 further on you said you have made some arrangement with the  
25 Workmen's Compensation Board that after 14 treatments you have



DR. HAMILTON: Would you say that again? You're

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a couple of questions for clarification. Recommendation 8  
"that treatment may be continued for as long as may be deemed  
necessary in the opinion of the chiropractor". Some place  
further on you said you have made some arrangement with the



1 a consultation and you refer somehow. Could you give us any  
2 idea of how you and the Workmen's Compensation Board arrived  
3 at this 14 figure?  
4 MR. SUTHERLAND: Some years ago it was required  
5 by the Board after 14 days there would be a medical confirmation  
6 of the condition. However, that requirement was dispensed with quite  
7 a few years ago. I can't give you an exact date. Today the  
8 chiropractor checks with the Compensation Board, sometimes  
9 by phone, sometimes by letter explaining the progress of the  
10 condition and an extension beyond 14 days is the general rule.  
11 It is granted. If the chiropractor thinks the patient is  
12 not progressing sufficiently well he may recommend the patient  
13 be referred to an orthopaedic specialist or some other special-  
14 ist.

15 MR. MAJOR: If this patient is referred to an  
16 orthopaedic specialist for an opinion, as it were, does the  
17 patient return to you?

18 MR. SUTHERLAND: Yes.

19 MR. MAJOR: Or does the orthopaedist . . .

20 MR. SUTHERLAND: There are cases where the  
21 orthopaedist states treatment should be continued. There are  
22 other cases where he feels another approach ought to be  
23 tried, and if this is the recommendation the Board usually  
24 approves of this and the chiropractor receives a report.

25 MR. MAJOR: Down at the bottom of that page, under



1 a consultation and you refer someone. Could you give us any  
2 idea of how you and the Workmen's Compensation Board arrived  
3 at this figure?

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13 orthopaedic specialist for an opinion, as it were, does the  
14 patient return to you?

15 MR. MAJOR: Or does the orthopaedist . . .

16 MR. SUTHERLAND: There are cases where the

17 other cases where he feels another approach ought to be

18 MR. MAJOR: Down at the bottom of that page, under



1 recommendation 12 you state there should be some provision to  
2 assure that the practitioner's account is actually paid. You  
3 are discussing here the fee-for-service basis and a schedule  
4 of fees agreed upon by negotiation with the Association. Did  
5 you listen to the discussion with the Labour people, the  
6 United Automobile Workers? I am not sure whether I found in  
7 your submission this statement or not. Would you be prepared  
8 to work solely under Government direction so that this could  
9 be thoroughly implemented, that your fees would always be in  
10 agreement with some negotiating body over here, maybe Government  
11 people, they would see to it you would be paid and for this  
12 result you would make sort of an arrangement with the Government?

13 MR. SUTHERLAND: Before the Royal Commission  
14 on Health Services we took the stand we approved of a nationally  
15 -sponsored health insurance program. We recommended it be  
16 supported by taxes. We stated we were willing to work within  
17 such a structure and would lend our support to develop this.

18 MR. MAJOR: Even though this may be a sort of  
19 Government administrative bureaucracy, and I use the word in  
20 its least obnoxious sense, you would still be prepared to  
21 subject the chiropractic profession to this control as a  
22 profession?

23 MR. SUTHERLAND: I would say, sir, if we had  
24 some say in the drawing up of the fee schedule, yes.

25 MR. GREENSHIELDS: Might we add to that, perhaps,

1 recommendation is you state there should be some provision to

2 assume that the practitioner's account is actually paid. You

3 are discussing here the fee-for-service basis and a schedule

4 of fees which would be payable with the consultation. It is

5 you listen to the discussion with the labor people, the

6 union people, and the business people, I am sure that I found in

7 your submission this statement or not. Would you be prepared

8 to work solely under Government direction so that this could

9 be thoroughly implemented, that your fees would always be in

10 agreement with some negotiating body over here, maybe Government

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13 MR. SUTHERLAND: Before the Royal Commission

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25 MR. GREENWALD: Might we add to that, perhaps,





1 the ideal situation is such where there are pressures from  
2 various sides to keep everybody within reasonable lines. Mr.  
3 Major, your feeling of Government getting on one side would  
4 go too far one way, there has to be a balance fixed somewhere.  
5 How to achieve that is the real problem.

6 MR. MAJOR: Would you be prepared to work for  
7 this authoritative body on a salary basis rather than fee-for-  
8 service?

9 MR. GREENSHIELDS: Many doctors do and they are  
10 very happy to do so.

11 MR. MAJOR: It has been my personal feeling  
12 that health care must include a reasonable amount of preventive  
13 services. I am thinking of those preventive services that are  
14 in the area, I believe your term is chemo-therapy, injections  
15 and shots for children, Salk vaccine and so on. If we are  
16 going to achieve this on a basic program this would be in  
17 opposition to your recommendation 13 where you say that  
18 "A patient should be charged a utilization or deterrent fee",  
19 in other words a deterrent fee may deter members of the public  
20 from ordinary basic preventive services.

21 MR. GREENSHIELDS: May I answer that: at present  
22 the arrangement with the Co-operative Federation for Chiropractic  
23 Services requires a payment of \$1 by a patient for each visit.  
24 Some of the insurance plans don't pay 100% of the visit. It leaves  
25 the patient with 50¢ a visit or some small amount to pay like that,



the ideal situation is such where there are pressures from various sides to keep everybody within reasonable limits. Mr. Mayor, your feeling of Government getting on one side would go too far one way, there has to be a balance fixed somewhere. How to achieve that is the real problem.

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the arrangement with the Co-operative Federation for Chiropractic

Some of the insurance plans don't pay 100% of the visit. It leaves



1 and weighing in the balance again, if it is a minimum amount  
2 we feel that this prevents abuse or waste of service and  
3 doesn't prevent the person from getting the service that is  
4 necessary. I agree with you a large fee of \$2 per visit or  
5 \$3 might make a handicap.

6 MR. MAJOR: This is discrimination as it were,  
7 where you are paying a prudent charge by way of deterrent fee.  
8 The delegation prior to you wouldn't agree with even 5¢, would  
9 they. The question I am coming to is something like this: If  
10 you agree that the ordinary preventive measures should be  
11 implemented, would you be prepared to have these implemented over  
12 here and you on your services have a deterrent fee? Maybe I  
13 should reverse it: supposing, for instance, there is another  
14 program of Salk vaccine. As I understand it your profession  
15 wouldn't be allowed to administer Salk vaccine; is that correct?

16 MR. GREENSHIELDS: Correct.

17 MR. MAJOR: In these cases would you be prepared  
18 to give the benefit of the doubt to these professions who can  
19 handle this by law and still allow your service to have a deter-  
20 rent fee?

21 MR. GREENSHIELD: Might I answer it this way:  
22 your general run of medical care that is needed by the individual,  
23 we feel that a deterrent fee would be wise. In a specific  
24 program set up by Government or agency which considered the  
25 need and economies of it, I certainly think we would go along



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4 necessary. I agree with you a large fee of \$2 per visit or  
5 \$3 might make a handicap.

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22 Your general run of medical care that is needed by the individual

23 we feel that a deterrent fee would be wise. In a specific



1 with whatever was in the best interest that way.

2 MR. MAJOR: If the authority looking after this  
3 could set up the sort of preventive program that would have  
4 no deterrent that would seem reasonable to you even if you  
5 had a deterrent on your profession.

6 MR. GREENSHIELDS: Maybe five years from now  
7 there would be some industrial survey or school posture service  
8 in which we would be participating and there would be no  
9 deterrent.

E/RPS 10 MR. MAJOR: On page 4, for clarification -- and  
11 I may have missed the point someplace through here -- paragraph  
12 21, the last few words:

13 "Recommendations from the professional  
14 "associations are considered, acted upon, or  
15 "passed to the Department."

16 What Department do you have in mind there?

17 MR. BEASLEY: That is referring to the Department  
18 of Health.

19 MR. MAJOR: I have another question. In para-  
20 graph 22 it states:

21 "Authority of the Board applies to all

22 "registrants, . . ." and so on. That is

23 paragraph 22. I want you to think of this question, because

24 I am prone to ask it. If I, as an individual, presented myself

25 to you as a practitioner -- and I think Dr. Hamilton said many



with whatever was in the best interest that way.

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could set up the sort of preventive program that would have

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graph 22 it states:

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"registrants, . . . " and so on. That is

paragraph 22. I want you to think of this question, because

I am going to ask it -- Mr. H. as an individual, professional, private

is not a registrant -- and I agree Mr. Hensler with you





1 people will go to a health person, not knowing anything about  
2 what is wrong with them -- and you, by some chance of negligence  
3 or oversight, miss your diagnosis to the harm of my person, can  
4 you be sued? What is your responsibility under the law?

5 MR. SUTHERLAND: There was an example several  
6 years ago like that in Ontario where a chiropractor was found  
7 negligent in that he did not use a stethoscope on a patient's  
8 chest. He missed a condition and he was taken to court over  
9 the matter and he was found negligent.

10 MR. MAJOR: Your answer is then that you can  
11 be sued under the law?

12 MR. SUTHERLAND: Yes.

13 MR. BEASLEY: May I add to that that a practitioner  
14 is responsible for the care and treatment of the patient. Not  
15 only would he be open to this civil action, but he would also  
16 be responsible to the Board. If he should exhibit negligence  
17 in his practice, there would be a disciplinary hearing.

18 MR. MAJOR: There would be the two things. When  
19 he was finished with the civil courts, he would be back on  
20 our shoulders?

21 MR. BEASLEY: That is correct.

22 MR. SUTHERLAND: And the case I referred to  
23 established that the chiropractor is obliged to make a diagnosis  
24 of the patient's condition.

25 MR. MAJOR: On page 11, let us consider fees



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21 MR. SUTHERLAND: And the case I referred to

22 established that the chiropractor is obliged to make a diagnosis

23 of the patient's condition.

24 MR. MAJOR: On page 11, let us consider fees



1 for a moment. In paragraph 57:

2 "Currently office visits are paid at the  
3 "rate of \$3.50, house calls at \$5 . . . "

4 In paragraph 58:

5 "Fees paid by the Board are below the  
6 "average standard fee charged for similar services  
7 "to private patients . . . "

8 Can you give us the fees that the Board pay  
9 in respect to the actual fees that you charge in private  
10 practice. I am talking about the schedule. Some practitioners  
11 charge more or less.

12 MR. WATKINS: Items 57 and 58 refer to the  
13 Workmen's Compensation Board current schedule of fees in which  
14 they pay \$3.50 per visit, and that is based on the fact that  
15 there is one hundred per cent collection of accounts, is not  
16 like that, but is paid alike to all practitioners who are  
17 paid for services by the Workmen's Compensation Board. Later  
18 in our brief we outline that the average basic fee for office  
19 service in the profession is \$4.

20 MR. MAJOR: And the home fee?

21 MR. WATKINS: And the home fee is \$5 and in  
22 some cases \$6.

23 MR. MAJOR: In paragraph 60, you have a patient  
24 that you have started to treat as a patient under the Board and  
25 then it is found that the patient doesn't come under the Board;



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in respect to the actual fees that you charge in private

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like that, but is paid alike to all practitioners who are

paid for services by the Workmen's Compensation Board. Later

in our brief we outline that the average basic fee for office

MR. MAJOR: And the home fee?

MR. WATKINS: And the home fee is \$5 and 10

some cases \$6.

MR. MAJOR: In paragraph 60, you have a patient

that you have started to treat as a patient under the Board and



1 what do you charge that patient then, your private fee, or  
2 do you just charge him the Board fee because of the start of  
3 the case as a Board case?

4 MR. WATKINS: The patient pays no fee whatsoever,  
5 in view of the fact that he supposed he was covered under  
6 Compensation and, therefore, when the Board rules that he  
7 is not a compensation case, then he is charged as a regular  
8 office patient.

9 MR. MAJOR: You charge the private practice fee?

10 MR. WATKINS: Yes.

11 MR. MAJOR: Now, on page 12, 66, do you do eye  
12 examinations to any degree?

13 MR. BEASLEY: No, sir.

14 MR. MAJOR: You don't? What if somebody came  
15 into your office with eye trouble? You would just refer them  
16 immediately? Is that the picture here?

17 MR. SUTHERLAND: You mean visual defects?

18 MR. MAJOR: Yes.

19 MR. SUTHERLAND: Oh, yes. We refer them to an  
20 optometrist or an ophthalmologist.

21 MR. MAJOR: On page 17, paragraph 92, at the  
22 bottom of the page you indicate that there are approximately  
23 450 X-ray machines in use by chiropractors in Canada. Can you  
24 give me any estimate of how many are in use in Ontario?

25 MR. MacDOUGALL: I think about 51% of the



1. The following is a list of the names of the persons who have been  
2. appointed to the position of Commissioner of the Labor Department,  
3. and the date of their appointment.

4. MR. WATKINS: The patient pays no fee whatsoever  
5. in view of the fact that he supposed he was covered under  
6. Compensation and, therefore, when the Board rules that he  
7. is not a compensation case, then he is charged as a regular  
8. patient.

9. MR. MAJOR: You charge the private practice fee?  
10. MR. WATKINS: Yes.

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13. MR. REASLEY: No, sir.

14. MR. MAJOR: You don't? What if someone came  
15. into your office with eye troubles? You would just refer them  
16. immediately? Is that the picture here?  
17. MR. SUTHERLAND: You mean almost always?

18. MR. MAJOR: Oh, yes. We refer them to an  
19. optometrist or an ophthalmologist.

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21. bottom of the page you indicate that there are approximately  
22. 450 X-ray machines in use by chiropractors in Canada. Can you  
23. give me any estimate of how many are in use in Ontario?  
24. MR. McDONALD: I think about 216 of the





1 practitioners have them. Of those in sole practice, I think it  
2 is 49% have X-ray units. Those in multiple practice, I believe  
3 it is 56 or 57%. But the average would be close to 50%.

4 MR. MAJOR: What is the number of practitioners  
5 in Ontario?

6 MR. SUTHERLAND: Five hundred and sixty-four,  
7 I believe.

8 MR. MAJOR: On page 18, paragraph 97, I find  
9 this very interesting statement, the last two lines of the  
10 paragraph:

11 "... that none of the chiropractors of  
12 "Canada concerned with the survey, received  
13 "more than 25 per cent of the maximum permissible  
14 "dose during the period of survey."

15 I immediately thought of what is the dose the  
16 patient receives? Are there any studies done on that?

17 MR. GREENSHIELDS: That has been covered very  
18 thoroughly by the Atomic Energy Commission and the related  
19 counterparts. The big problem there is not with patient dosage  
20 with diagnostic terminology. It is only when there are  
21 therapy problems that the patient dosage is really involved  
22 extensively. The usual thing here is that the problem of  
23 secondary radiation affecting the operator is the most dangerous  
24 part of it in most laboratories, but that is handled very well  
25 in our hospital facilities and it is in many of the private



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1 practices where the lack of knowledge of the whole thing leads  
2 to disregard of radiation.

3 MR. MAJOR: It is a matter then of continued  
4 exposure by the operator?

5 MR. GREENSHIELDS: Yes. It is accumulated  
6 exposure.

7 MR. MAJOR: As far as you know, the patient does  
8 not suffer from this, unless the patient was X-rayed every  
9 day, or something?

10 MR. GREENSHIELDS: In that case, there would be  
11 a problem any place where there had been problems which will  
12 reveal indiscriminate use.

13 THE CHAIRMAN: In your practice, have you any  
14 idea of how many times a patient may be subjected to X-rays,  
15 to give you the progress that you are making in the manipulation  
16 and the mechanics of this procedure?

17 MR. WATKINS: The immediate problem is the  
18 first examination in evaluating the body structure, whether  
19 or not there is any pathologic problem, and the major mal-  
20 formations that would be misleading on the surface to examination  
21 by palpitation, et cetera. From that preliminary examination  
22 on, there is a very small percentage of re-examination.

23 MR. MAJOR: As far as X-rays?

24 MR. WATKINS: As far as X-ray examination. From  
25 there on, the majority is done without that. Some people say



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on, there is a very small percentage of re-examination.

MR. MAJOR: As far as X-rays?

MR. WATKINS: As far as X-ray examination. From



1 it would be ideal to X-ray them before and after each call,  
2 but that would be imbecilic.

3 MR. MAJOR: On page 40, paragraph (n):

4 "It is conservatively estimated that  
5 "40% of the people of Canada have utilized the  
6 "services of chiropractors".

2 7 "... have utilized" is a little different  
8 than "are utilizing" and I would like to translate "are  
9 utilizing" in terms of Ontario.

10 MR. GREENSHIELDS: Our statistics show that  
11 approximately 82,000 patients do attend chiropractors each  
12 year in the Province of Ontario. That is a conservative  
13 estimate. We had a notion someone might ask this and we tried  
14 to arrive at some statistics or figures for Ontario and we  
15 deduced that 20 to 25%, or approximately 2,000,000 people in  
16 Ontario, have attended or in their lifetime had experience with  
17 a chiropractor. As you can appreciate, it is difficult to  
18 say in any given period how many are utilizing our services.  
19 But, taken over a period of 30 years, we worked this out, that  
20 this would be pretty close -- a pretty accurate figure -- approx-  
21 imately 2,000,000 or 20 to 25% in Ontario.

22 MR. MAJOR: The statement "have had experience  
23 with a chiropractor" . . .

24 MR. GREENSHIELDS: That is, perhaps, a poor  
25 choice of words.

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deduced that 20 to 25% or approximately 2,000,000 people in

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a chiropractor. As you can appreciate, it is difficult to

say in any given period how many are utilizing our services

But, taken over a period of 30 years, we worked this out, that

this would be pretty close -- a pretty accurate figure -- approx

MR. MAJOR: The statement "have had experience

with a chiropractor" . . .

MR. GREENSHIELDS: That is, perhaps, a poor

choice of words.





1 MR. MAJOR: Could I put the question this way:

2 Do chiropractors, as a profession, carry on as a family  
3 physician? Don't count the word "physician" in its wrong  
4 connotation.

5 MR. GREENSHIELDS: Yes.

6 MR. MAJOR: You look after a family the same  
7 as a general practitioner in medicine?

8 MR. GREENSHIELDS: In many respects, yes.

9 MR. MAJOR: And from this family you refer to  
10 the medical practitioner for this organic condition and this  
11 family then comes back to you?

12 MR. GREENSHIELDS: Exactly.

13 MR. MAJOR: Have you any idea as to the number  
14 of people in Ontario that would use you as a family physician?  
15 Is there five hundred thousand men, women and children in  
16 Ontario, or a million, or a broad guess, as to the number of  
17 people that would look to you in your profession as a family  
18 physician?

19 MR. SUTHERLAND: That is a difficult question  
20 to answer.

21 MR. MacDOUGALL: There are some who not only  
22 have a family chiropractor, but also a family physician and  
23 a family religious counsellor. Then of those they are usually  
24 able to determine who is going to be their first choice.

25 MR. MAJOR: They do a little of their own



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22 have a family chiropractor, but also a family physician and

23 a family religious counsellor. Then of those they are usually

24 able to determine who is going to be their first choice.

25 MR. MAJOR: They do a little of their own



1 diagnosis as they go on and choose which one they want?

2 MR. MacDOUGALL: Yes.

3 MR. MAJOR: Thank you. That is all I have.

4 THE CHAIRMAN: Ladies and gentlemen, it was  
5 agreed that we would carry through until one o'clock and then  
6 adjourn for lunch. So I think we will proceed with the agreed-  
7 upon program and then we can look forward to meeting you here  
8 at approximately quarter after two.

9 MR. NAYLOR: Mr. Chairman, would it be  
10 worth while considering if there are a sufficient number of  
11 questions to make it worth while coming back?

12 THE CHAIRMAN: Mr. Mulrooney was also going to  
13 have some questions. Are your questions going to be very long,  
14 Mr. Mulrooney?

15 MR. MULROONEY: No. There are a few questions,  
16 quite brief. Most of the other material has been covered.

17 THE CHAIRMAN: And Dr. Butt?

18 DR. BUTT: I had one, but I can defer it,  
19 Mr. Chairman.

20 THE CHAIRMAN: If you are willing, I am certainly  
21 game to carry on. Should we put a further time limit on it  
22 of one twenty then, we will say. We will work toward that.  
23 We will carry on then and see if we can get through it.

24 Mr. Naylor, did you say that you do not have  
25 any questions?



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MR. MAJOR: Thank you. That is all I have.

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game to carry on. Should we put a further time limit on it

of one twenty then, we will say. We will work toward that.



1 MR. NAYLOR: No, thank you.

2 THE CHAIRMAN: Mr. Mulrooney?

3 MR. MULROONEY: On page 9, paragraph 49, you  
4 state:

5 "Types of injuries treated for the Board  
6 "include care of various kinds of spinal injur-  
7 "ies, and strains and sprains affecting the  
8 "neuro-musculo-skeletal systems."

9 Other than strains and sprains, what services  
10 are payable by the Workmen's Compensation Board to chiropractors?

11 MR. SUTHERLAND: They must be attributed directly  
12 to an accident and be related to that.

13 MR. MULROONEY: I would like to know whether  
14 the compensation board compensation to chiropractors is restricted  
15 to treatment of sprains and strains?

16 MR. MacDOUGALL: No. I know of one particular  
17 case that came to my attention, a person who suffered an  
18 electric shock at work and severe muscular contraction as well,  
19 which produced extensive headaches for some period of time  
20 and this case was a compensation case.

21 MR. MULROONEY: Wouldn't muscular contraction be  
22 a sprain or strain?

23 MR. MacDOUGALL: Well, it is closely related,  
24 I suppose. But the feeling in this case was that it produced  
25 mis-alignment in the spine due to severe contraction of the



MR. NAYLOR: No, thank you.

MR. MURDOCK: On page 9, paragraph 4, you

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"include cases of various kinds of spinal injury-

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MR. MURDOCK: Well, it is closely related.

I suppose But the feeling in this case was that it produced

mis-alignment in the spine due to severe contraction of the





1 affected nerve groups, causing headaches and dizziness.

2 MR. SUTHERLAND: We do not believe in the  
3 Compensation Act it would spell this out, but the majority  
4 of accident cases that we would see would involve sprains  
5 and strains. But I do not believe that the Act spells that  
6 out.

7 MR. MULROONEY: What I am trying to determine  
8 is the area that is covered, that the Workmen's Compensation  
9 Board will cover and for which it will be chiropractors. Is  
10 this generally related to strains and sprains and no other  
11 treatment?

12 MR. SUTHERLAND: I do not believe it spells  
13 that out in the Act. But in our office this is what we see  
14 as a result of compensation injuries.

15 MR. PARTLOW: That would be the result of the  
16 fact that the compensation board covers cases only that are  
17 the result of an accident. You have to relate it back to that.

18 MR. MULROONEY: I understand that. On page 18,  
19 paragraph 95, you state:

20 "In the training of chiropractic students,  
21 "198 hours of instruction are provided by the  
22 "Canadian Memorial Chiropractic College in  
23 "all phases of radiography, and 576 hours of  
24 "clinic practice are provided wherein the  
25 "student applies his training before graduation."

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22 "Canadian Memorial Chiropractic College in

23 "all phases of radiography, and 576 hours of

24 "clinic practice are provided wherein the

25 "student applies his training before graduation."



1 This is, presumably, training in radiography.  
2 In the succeeding paragraphs you speak of post-graduate work  
3 in the field of radiology. Now, in the training of students,  
4 it seems to me that you speak here of teaching the art and  
5 the science of radiology, which I interpret to mean the  
6 production of the films; that as far as radiology is concerned,  
7 you seem to relate this in the following paragraph to post-  
8 graduate work. Does this mean that chiropractors develop  
9 specialists in radiology?

10 MR. GREENSHIELDS: This might well be a matter  
11 of definition. It may be that this word "radiography" should  
12 have been "roentgenography", referring to not only the making  
13 of the films but the interpretation of the mechanical defects  
14 of the skeletal system through the interpretation of tumors,  
15 possibly, and malignancies and other things which should be  
16 referred elsewhere, because a graduate of that is devoted to  
17 interpretation. So these are not technicians that are produced;  
18 these are individuals who are specifically trained in determining  
19 the mechanical defects and any other pathological treatment  
20 would be subject to consultation with a chiropractor.

21 MR. MULROONEY: The use of "radiography" twice  
22 in paragraph 95 and "radiology" in the following paragraph seemed  
23 a little difficult.

24 Now, this 198 hours of instruction, presumably,  
25 is the full course then in both radiography and radiology; is this





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graduate work. Does this mean that chiropractors develop  
specialists in radiology?

MR. GREENBERG: This might well be a matter  
of definition. If you are talking about radiography, which  
has been the traditional specialty of the radiologist, then  
the answer is no. The traditional specialty of the radiologist  
is the radiologist's specialty, which is radiography, or X-ray  
possibly, and malignancies and other things which should be  
referred elsewhere, because a graduate of that is devoted to  
radiography. If you are talking about the radiologist's specialty  
in the field of radiology, which is radiography, then the answer  
is yes. The radiologist's specialty is radiography, which is  
the traditional specialty of the radiologist, which is radiography.  
would be subject to consultation with a chiropractor.

MR. MULROONEY: The use of "radiography" twice  
in paragraph 10 is a little confusing. Now, this 108 hours of instruction, presumably,



1 correct?

2 MR. GREENSHIELDS: The term "radiology" also  
3 includes the use of ionizing radiation, et cetera. This would  
4 have been better worded "roentgenography", referring to the  
5 interpretation of the films.

6 MR. MULROONEY: My question really is: How  
7 does this compare with the training of the medical specialist  
MR/RPS 8 who does I understand five years post graduate work  
9 before he is certified as a specialist in radiology?

10 MR. WATKINS: There is a certification program  
11 at the present time in which the graduate studies must cover  
12 a period of five years before any certification is accomplished.  
13 This 198 hours is undergraduate work which compares more than  
14 favourably with the standard of the medical school, with  
15 undergraduates in roentgenology, as far as I can understand.

16 MR. MULROONEY: What I am trying to arrive at,  
17 obviously, is the qualifications for interpretation of the  
18 shadows in an X-ray development?

19 MR. WATKINS: Even as certified chiropractic  
20 roentgenologists we are not pretending to know all about every  
21 kind of tumor, but we are definitely endeavouring to have the  
22 individual able to recognize where there is something that  
23 should be referred to some specialist who is doing say, neurolog-  
24 ical, radiography, and some other specialization, not just  
25 radiography. Indeed, the medical radiologist is specializing



1

2

3

4

5 interpretation of the films.

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7 does this compare with the training of the medical specialist

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21 kind of tumor, but we are definitely endeavoring to have the

22 individual able to recognize where there is something that

23 should be referred to some specialist who is doing any radiology

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25 radiology. Indeed, the medical radiologist is specializing





1 in it appreciably more but this specialization is primarily  
2 in mechanical evaluation and as far as the pathological part,  
3 it is largely a matter of medically recognizing it, and then  
4 refer to the ultra specialists, if you want to put it that  
5 way.

6 MR. MULROONEY: You say mechanical evaluation,  
7 you are referring to the mechanics of the human body?

8 MR. WATKINS: Right.

9 MR. GREENSHIELDS: Mr. Chairman, if we might  
10 add another point to this and that is the medical college lists  
11 approximately 25 hours of instructions in X-ray work. 25 hours  
12 of lecture in X-ray work and that compares to the 198 hours  
13 of classroom work that the chiropractic student has, plus the  
14 number of hours in his clinical work that are added to that,  
15 so that we think considerably more time is spent in training  
16 in regard to X-rays and interpretation thereby than the average  
17 physician does.

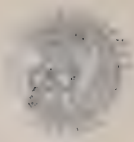
18 MR. MULROONEY: This is true of the physician  
19 in general practice?

20 MR. GREENSHIELDS: Yes.

21 MR. MULROONEY: This does not apply, when you  
22 are speaking of the specialists in radiology?

23 MR. GREENSHIELDS: They come in between.

24 MR. MULROONEY: Your physician, in general  
25 practice, very rarely uses X-ray.



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in mechanical evaluation and as far as the pathological part,  
it is largely a matter of medical recognition, and then  
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you are referring to the mechanics of the human body?

MR. GREENSHIELDS: Mr. Chairman, if we might

add another point to this and that is the medical college lists  
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of classroom work that the chiropractic students get, plus the  
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so that we think considerably more time is spent in education  
in regard to X-rays and interpretation thereof than the average

MR. MURDOCK: This is true of the physician

in general practice?

MR. MURDOCK: That does not apply, when you

are speaking of the specialists in radiology?

MR. GREENSHIELDS: They come in various



1 MR. WATKINS: On the contrary sir in the  
2 Metropolitan area of New York, the inspector there for radiation  
3 said there are some 18,000 units in Metropolitan New York and  
4 he said 85% of them are in the offices of the individual M.D.,  
5 private practice.

6 MR. MULROONEY: That is New York?

7 MR. WATKINS: In New York.

8 MR. MULROONEY: What are the comparable figures  
9 for Ontario?

10 MR. WATKINS: I don't have those at hand.

11 MR. SUTHERLAND: The Workmen's Compensation Board  
12 sir makes a distinction here. They pay the radiologist a  
13 certain fee for X-ray work and they pay the general practitioner  
14 75% of that fee if he provides service. Our fee from the  
15 Workmen's Compensation Board is equivalent to the general  
16 practitioner's fee.

17 DR. BUTT: Do you get paid for your X-rays  
18 from the Workmen's Compensation Board?

19 MR. SUTHERLAND: Yes sir, we do.

20 DR. BUTT: As general practitioner?

21 MR. SUTHERLAND: Yes.

22 DR. BUTT: For what X-ray?

23 MR. SUTHERLAND: Skeletal X-ray, spinal.

24 MR. GREENSHIELDS: In the area of the injury.

25 MR. SUTHERLAND: Spinal and extremities.





1 said there are some 18,000 units in Metropolitan New York and  
2 he said 85% of them are in the offices of the individual M.D.s.  
3 private practices.

4 MR. MURKOWITZ: That is New York.

5 MR. WALKER: In New York.

6 MR. MURKOWITZ: What are the corporate figures

7 for Ontario?

8 are asked a distinction here. What pay are we talking a

9 certain fee for X-ray work and not pay the general practitioner

10 and of them to be a service. Can you tell me

11 Dr. Brown: Is your fee paid for your X-rays

12 from the Washington Commission on Health?

13 MR. MURKOWITZ: Yes sir, is that

14 for your X-ray?

15 MR. MURKOWITZ: In the area of the injury.

16 MR. MURKOWITZ: General and experienced.



1 DR. BUTT: Do you submit your X-rays?

2 MR. SUTHERLAND: Yes, we do.

3 DR. BUTT: How many X-rays do you take on the  
4 back? Of what type?

5 MR. GREENSHIELDS: The Board requires at least  
6 two views and more according to certain injuries.

7 DR. GALLOWAY: Mr. Chairman, I think these  
8 gentlemen should be aware that you became a very disturbing  
9 and discouraging group to us because your brief was No. 1  
10 on our list.

11 MR. SUTHERLAND: We are aware of that sir.

12 DR. GALLOWAY: It gave us some idea of what  
13 we are going to expect with briefs all the way through. The  
14 point we want to make is that we had read this brief before  
15 we went to Windsor and listened to your confreres speaking in  
16 that area. There are a number of questions that they have  
17 answered for us. There are only two points and they have to  
18 do with insurance that I would like to clarify with you as  
19 a group. Have you any idea of the percentage of your practice  
20 that is now covered by insurance excluding the Workmen's  
21 Compensation Board? Have you a rough estimate of your individual  
22 practice?

23 MR. GREENSHIELDS: That would vary very greatly  
24 according to the group plan in the area. For example, in  
25 some towns where a large industry is covered by an insurance



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according to the group plan in the area. For example, in

some towns where a large industry is covered by an insurance





1 carrier that includes chiropractic, then the percentage in that  
2 town would be much higher than a town where it will not include  
3 it in their package benefits of a large industrial firm and  
4 so it is very difficult for us to give you say an average,  
5 33 or 66% without making a survey of it.

6 DR. GALLOWAY: Do you know enough about these  
7 insurance plans that do cover chiropractic work as to whether  
8 or not they are in the basic plans, the coverage obtained or  
9 whether they are on extended health benefits or major medical  
10 plans?

11 MR. GREENSHIELDS: It is in both sir. It varies  
12 some with the various companies. We have outlined on one  
13 page here the various ways in which insurance is covered.

14 DR. GALLOWAY: You suggested there are 560  
15 chiropractors in Ontario. We were given a fee for the average  
16 number of individuals a chiropractor would treat during the  
17 day when we were in Windsor. I wondered if you could give  
18 me an approximate idea whether or not that figure would be  
19 correct in practice in Toronto, or could you give me an idea  
20 of the number of patients you would treat per day, the average  
21 practitioner in Toronto?

22 MR. SUTHERLAND: The average number of visits  
23 per day is in the neighbourhood of 20, give or take a few.  
24 We feel the average per week is about 80. Is that the substance  
25 of your question?



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per day is in the neighborhood of 20, give or take a few.

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1 DR. GALLOWAY: Yes. The reason I am asking  
2 this is to try and estimate, if your services are insured,  
3 what the costs are going to be.

4 MR. GREENSHIELDS: May I elaborate on your  
5 last point a little? In estimating what the costs would be,  
6 we have put down a figure here of \$6 million as being an  
7 approximation of the total value of the service that we are  
8 rendering in the Province, but it does not follow that it would  
9 cost \$6 million to include our service in any plan because,  
10 first of all, this figure covers Workmen's Compensation which  
11 would not fall within Bill 163 and also it would cover some  
12 people who by utilizing our service would not be putting any  
13 charges in for Ontario Hospital Services so there would be  
14 a change in regard to the different plans and, further, that  
15 if many of these people had our service, then the physician  
16 would not be dealing with that service so that we cannot just  
17 take a blanket figure and say this is going to cost that much  
18 to add chiropractic because if people were receiving chiro-  
19 practic care, according to our recommendations, they would not  
20 be getting medical care at the same time for the same condition.

21 DR. GALLOWAY: Do you have many inter-chiropractic  
22 consultations?

23 MR. GREENSHIELDS: Yes sir.

24 DR. GALLOWAY: What percentage of your practice  
25 would that be? In other words, you must have specialists who





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DR. GALLAGHER: What percentage of your practice

would that be? In other words, you must have specialists who



1 would be charging a consultation fee?

2 MR. GREENSHIELDS: Our College sir has felt  
3 a need in that regard in which problem cases are referred there  
4 to the clinic director. I don't have that percentage with  
5 me.

6 DR. GALLOWAY: At the present moment those  
7 people would be charged a fee even when they go to the college  
8 clinic?

9 MR. GREENSHIELDS: Yes sir.

10 DR. GALLOWAY: Thank you very much.

11 THE CHAIRMAN: I feel that I must yield to  
12 this temptation to ask a question which is rather undiplomatic.  
13 I couldn't help but wonder sitting here listening to some  
14 of these questions which have been asked what your qualifications  
15 are in diagnosis and your ability to recognize ailments which  
16 you have admitted your profession does not treat and would  
17 refer, if the tables were reversed here would you have been  
18 asking questions of these physicians as to their ability to  
19 recognize things which might be better-treated by a chiropractor  
20 than by a physician? If you do not wish to answer that question,  
21 you do not need to.

22 MR. SUTHERLAND: I think in our brief sir and  
23 in some of the exhibits, it has been pointed out that the  
24 medical profession has perhaps not realized the full significance  
25 of referred pain from the spine. There are a number of works by



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a need in that regard in which problem cases are referred there

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me.

DR. GALLOWAY: I don't know, I don't know.

people would be charged a fee even when they go to the college

clinic?

DR. GALLOWAY: I don't know, I don't know.

DR. GALLOWAY: Thank you very much.

THE CHAIRMAN: I feel that I must yield to

this temptation to ask a question which is rather unpolitic.

I couldn't help but wonder sitting here listening to some

of these questions which have been asked what your qualifications

are in diagnosis and your ability to recognize ailments which

are in the nature of a chronic condition.

DR. GALLOWAY: I don't know, I don't know.

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DR. GALLOWAY: I don't know, I don't know.

MR. SUTHERLAND: I think in our brief and

in some of the exhibits, it has been pointed out that the

medical profession has perhaps not realized the full significance

of referred pain from the spine. There are a number of works by





1 Manell written on this subject. Manell points out if errors  
2 in diagnosis are to be reduced, then the significance of  
3 nerve group irritation from the spine must be taken into account  
4 and he goes on to point out it has not been taught in medical  
5 schools because of the air of mysticism that surrounds this  
6 treatment. We feel this mysticism is largely the result of  
7 the difference of opinion between the two professions which  
8 causes some confusion perhaps in the public mind, but we feel  
9 that definitely there are errors in diagnosis. In fact, Manell  
10 pointed out that one patient was treated for a heart condition  
11 for years when in fact she had symptoms of angina which were  
12 due to a vertebral problem at the base of her neck which we  
13 corrected by manipulation after they discovered the cause. Now  
14 I suppose it could be asked from the other side of the fence  
15 that the chiropractor might also see a case that perhaps requires  
16 medical care. I think there are certainly errors in both fields.  
17 We try to keep these to a minimum but certainly the basis should  
18 be established for more co-operation between the two groups so  
19 that a patient with the symptoms of gall bladder disease should  
20 be treated by the most effective means, whether a spinal problem  
21 or whether the gall bladder is actually inflamed. We would  
22 like to see more co-operation so that the patient can receive the  
23 best care.

24 THE CHAIRMAN: Thank you. Are there any further  
25 questions from the members of the Enquiry? Do you have  
any further statement?



Manell writes on this subject. Manell points out in errors in diagnosis are to be reduced, when the significance of nerve group irritation from the spine must be taken into account and he goes on to point out it has not been taught in medical schools because of the air of mysticism that surrounds this treatment. We feel that mysticism is largely the result of the difference of opinion between the two professions which causes some confusion perhaps in the public mind, but we feel that definitely there are errors in diagnosis. In fact, Manell pointed out that one patient was treated for a heart condition for years when in fact she had symptoms of angina which were due to a vertebral problem at the base of her neck which we corrected by manipulation after they discovered the cause. Now I suppose it could be asked from the other side of the fence that the chiropractor might also see a case that perhaps requires medical care. I think there are certainly errors in both fields. We try to keep these at a minimum but certainly, the basis should be established for more co-operation between the two groups so that a patient with the symptoms of gall bladder disease should be treated by the most effective means, whether a spinal problem or whether the gall bladder is actually inflamed. We would like to see more co-operation so that the patient can receive the best care.



1 MR. GREENSHIELDS: No sir.

2 THE CHAIRMAN: Thank you very much. It has  
3 been very interesting.

4  
5 ---Luncheon Adjournment.  
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7 -----  
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MR. GREENSHIELDS: No sir.

THE CHAIRMAN: Thank you very much. It has

been very interesting.

— (Faint text, possibly a signature or title) —



/PB/RPS1 ---UPON RESUMING:

THE CHAIRMAN: Ladies and gentlemen, on behalf of the members of the Commission we apologize for keeping you waiting. We had the alternative of either completing the hearing this morning and remaining here until, I think it was around twenty minutes past one before we left or adjourning and then reconvening and meeting with the same delegation after lunch. Probably had we done that it would have been longer. I appreciate very much your willingness to bear with us. Have you had an opportunity to read the statement of instructions?

MR. KING: Yes.

THE CHAIRMAN: Would the spokesman for your group identify himself and introduce the other members of the delegation giving their titals and initials for the benefit of the press.

SUBMISSION OF THE VICTORIAN ORDER OF NURSES (ONTARIO)

Appearances: T.A. King, Q.C.  
Miss Catherine Maddaford  
Miss Ruby Good  
Mr. W.K. Cairns

MR. KING: Mr. Chairman, members of the Enquiry it is a great pleasure for us to have an Enquiry apologize to us rather than for us to apologize to the Enquiry. My name is King.

T.A. King. I am President of the Ontario Branch of the Order. I will act as spokesman for the Order for today. On my left is Miss Catherine Maddaford who is senior regional director for

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Appointees: T.A. King, G.C.

Miss Ruby Good

Mr. W.K. (name)

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1 Ontario. Next to her is Miss Ruby Good who is director of the  
2 York Township Branch and a part-time regional director of two  
3 or three other branches. Next to her is Mr. W.K. Cairns,  
4 C-A-I-R-N-S, who is a member of the Board of Directors of the  
5 Ontario branch and of the local branch at Weston. I am told that  
6 the Enquiry has read the brief and that there are only two or  
7 three comments that I will make at this time.

8 THE CHAIRMAN: Mr. King, if you feel just as  
9 comfortable being seated please feel free to be seated.

10 MR. KING: Thank you. If it is satisfactory to  
11 you I am required to stand most of the time and I feel uncom-  
12 fortably sitting.

13 The three points that the Order is making, the  
14 Enquiry will recall, is No. 1: That the benefit should extend  
15 to visiting nursing service in the home in certain cases. The  
16 second point is that the benefit should extend to preventive  
17 measures as well as curative and the third point is that the  
18 Order, the Victorian Order of Nurses is able and willing to  
19 participate in any plan that may be introduced. I would like  
20 to say a few words on each of these.

21 As to the first one I am sure it is not new  
22 to this Enquiry that the costs of maintaining patients in the  
23 hospital has been increasing and is enormous. It is probably  
24 not new to the Enquiry either that great thought has been given  
25 to home care plans in the United States. We have had a study



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...  
...  
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... G-A-I-R-N-2, who is a member of the Board of Directors of the  
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... measures as well as curative and the third point is that the  
... order, the Visitation Order, is to be extended to all  
... participants in the plan that are in the hospital, the home  
... to say a few words on the subject.  
...  
... hospital has been increasing and is enormous. It is probably  
... to home care plans in the United States. We have had a study



1 here in the City of Toronto for the past three or four years  
2 in the pilot home care study, which has just wound up its  
3 operation on an experimental basis. It has been the view of  
4 those groups, and particularly the view arising from the  
5 Toronto experiment that there is a definite place for home care,  
6 and of course, the cornerstone of a home care program is the  
7 nurse who must attend to the needs of the patient at the home.  
8 This has the result of getting people out of the hospital,  
9 returning of the patient to the home from the hospital sooner.  
10 This keeps down the cost of running the hospital, keeps down  
11 the number of hospital beds that may be needed and it can be  
12 done much cheaper in the home. I am sure the Enquiry is very  
13 interested in the question of costs. I am not sure how much  
14 help we may give on the question, but by all means press us.

15                   The legislation in this respect, and we think  
16 there is a definite need, and we think also there is a definite  
17 trend developing in the thinking of those people who are con-  
18 cerned with these problems to proceed with further experiments,  
19 and also further plans for home care, and that any legislation  
20 of this kind which provides for the payment of medical bills,  
21 but not for nursing bills for the home where the nurse is doing  
22 the type of work that a nurse would do in a hospital if the  
23 patient was kept in the hospital, we think this discourages the  
24 home care programs and I think legislation should encourage it.  
25 After all nursing in the home isn't the ordinary nursing, the





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1 Only in the City of Toronto for the past year or two years.  
2 In the last year or two, whereas last year was the  
3 year of the experimental basis. It was very difficult  
4 to make progress and particularly in the new areas.  
5 I think it is important that there is a definite plan for the future  
6 and of course, the cornerstone of a home care program is the  
7 nurse who must attend to the needs of the patient at the home.  
8 This has the result of getting people out of the hospital,  
9 returning of the patient to the home from the hospital sooner.  
10 This might seem to be a simple thing, but it is not.  
11 The number of hospital beds that are needed and the way  
12 they are used is very important. I am sure the hospital is very  
13 interested in the question of costs. I am not sure how much  
14 this is going to cost in the future, but it is a question.  
15 The legislation in this respect, and we think  
16 there is a definite need, and we think also there is a definite  
17 need to develop in the future of home care and the way  
18 it is being done. I think it is important to have legislation  
19 and also further plans for home care, and that any legislation  
20 that is passed should be in the form of a bill.  
21 I am not sure if it is the case where the law is made  
22 the type of work that a nurse would do in a hospital if the  
23 patient is sent to the hospital, as I think it is important to  
24 have some legislation that would be in the form of a bill.  
25 I am not sure if it is the case where the law is made



1 private nurse looking after the patient at home. This is  
2 nursing that is done under the direction, on the instructions  
3 and under the overall supervision of a doctor because he thinks  
4 it is necessary for that patient either to have this attention  
5 in the home or to go to the hospital.

6           The second point about preventive medicine,  
7 the Victorian Order of Nurses has always been concerned with  
8 both aspects, preventing illness and curing it after it had  
9 occurred. We think that this should be increasingly so in our  
10 society today. We know that the proposed legislation does not  
11 deal with it at all. As a matter of fact it excluded it. It  
12 is for that reason that we are suggesting the schedule be  
13 amended, and we refer to schedule A, exception No. 1, where  
14 it has excepted annual or periodic health examinations. It may  
15 be that those drafting the legislation felt there was a good  
16 reason for doing this. We consider that this is extremely  
17 important, to encourage people to go to the doctor, not to  
18 discourage them from going. The cost of the annual or periodic  
19 health examination cannot be that large in proportion to the  
20 benefits provided for the other areas in the legislation.

21           We also suggested, however, deleting from the  
22 exceptions new-born care, new-born infant care rendered by the  
23 physician delivering the infant. Quite frankly we didn't follow  
24 that. Not being able to follow it we suggested you delete it.  
25 Certainly if a physician renders the services if it is needed,



private nurse looking after the patient at home. This is nursing that is done under the direction, on the instructions and under the overall supervision of a doctor because he thinks it is necessary for that patient either to have this attention in the home or to go to the hospital.

The second point about preventive medicine, the Victorian Order of Nurses has always been concerned with both aspects, preventing illness and curing it after it had occurred. We think that this should be increasingly so in our society today. We know that the proposed legislation does not deal with it at all. As a matter of fact it excluded it. It is for that reason that we are suggesting the schedule be amended, and we refer to schedule 1, paragraph 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

We also suggested, however, deleting from the exceptions new-born care, new-born infant care rendered by the physician attending the infant. We have found no other provision that. Not being able to follow it we suggested you delete it. Certainly it is a provision rendered by a physician.





1 why shouldn't he still be paid the usual amount.

2           The third point is that the Victorian Order of  
3 Nurses would be delighted to use all its facilities and the  
4 increased facilities that it may have acquired as a result  
5 for the benefit of any program here in Ontario. It has a  
6 long history here and it has a great deal of experience and  
7 highly-trained staff, technical staff, administrative staff.  
8 The Order is in areas of the Province where live 72% of the  
9 people. It has 57 separate branches throughout the Province  
10 and we submit that the Victorian Order of Nurses is quite able  
11 and capable to pull in the resources it has in this regard.  
12 Thank you.

13           THE CHAIRMAN: Mrs. Aylen, any questions?

14           MRS. AYLEN: First I might say I think we are  
15 all quite familiar with the Victorian Order of Nurses and  
16 the amount of work they carry out. In particular the represent-  
17 ation made in this brief, when you came down to the last page --  
18 it isn't numbered. It is item 34. You state there are eight  
19 home care plans in Canada, two of which are in Ontario. Could  
20 you tell us just what the two plans are?

21           MISS MADDAFORD: Mr. Chairman, do I understand  
22 the question to be you want to know the eight?

23           MRS. AYLEN: Not the ones in Canada, just the  
24 two here in Ontario.

25           MISS MADDAFORD: There is one that is in Toronto,



The third point is that the Victorian Order of

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people. It has 57 separate branches throughout the Province

and we submit that the Victorian Order of Nurses is quite able

and capable to pull in the resources it has in this regard.

THE CHAIRMAN: Mrs. Ayles, any questions?

MRS. AYLES: First I might say I think we are

it isn't numbered. It is item 34. You state there are eight

You tell us just what the two plans are?

MISS MADDAFORD: Mr. Chairman, do I understand

the question to be you want to know the eight?

MRS. AYLES: Not the ones in Canada, just the

two here in Ontario.

MISS MADDAFORD: There is one that is in Toronto,



1 the Toronto Home Care Program in which the Victorian Order  
2 sells nursing services to the program. This is its relationship  
3 with this home care program in Toronto. They have always been  
4 active on the planning committee and on the advisory committee.  
5 Then there is a new plan which is being administered by the  
6 Victorian Order of Nurses in Ottawa, by the Ottawa branch.  
7 Here the Victorian Order is administering the plan. It is just  
8 nicely in its planning phase now. They haven't started to  
9 provide a service but they have the method to provide the home  
10 care plan and they are getting started now.

11 MRS. AYLEN: The Blue Cross have an extended  
12 health care plan. Do you have any experience with it?

13 MISS MADDAFORD: Not in Canada.

14 MRS. AYLEN: Yes, in Ontario, extended health  
15 care.

16 MR. KING: As far as I know we have had no  
17 experience.

18 MRS. AYLEN: I am asking that.

19 MR. KING: No.

20 MRS. AYLEN: In all these cases the patient is  
21 in the care of a physician?

22 MISS MADDAFORD: That is right.

23 MRS. AYLEN: Is there any special income group  
24 that you serve, low income group, medium or high? The people  
25 that you service with these home care plans, is there any special





1 This is the relationship between the nursing services to the program. This is the relationship  
2 with this home care program in Toronto. They have always been  
3 active on the planning committee and on the advisory committee.  
4 Then there is a new plan which is being administered by the  
5 Victorian Order of Nurses in Ottawa, by the Ottawa branch.  
6 Here the Victorian Order is administering the plan. It is just  
7 active in its planning phase now. They haven't started to  
8 provide a service but they have the method to provide the home  
9 care plan and they are getting started now.

10 MRS. AYER: The home care have an extended

11 health care plan. Do you have any experience with it?

12 MISS MARRAS: Not in Canada.

13 MRS. AYER: Yes, in Ontario, extended health

14 MR. KING: As far as I know we have had no

15 MRS. AYER: I am asking about.

16 MR. KING: No.

17 MRS. AYER: In all these cases the patient is

18 in the care of a physician.

19 MISS MARRAS: That is right.

20 MRS. AYER: Is there any special income group

21 that you serve, low income group, medium or high? The people



1 income group that are represented?

2 MR. KING: Yes. I don't believe I have the  
3 percentage here right now, but my recollection is that some-  
4 thing like 45% -- well, I am sorry. I am not clear on this.  
5 It is probably something we should check. The figure in my  
6 mind is 65% or 50% of the patients we serve are receiving some  
7 form of old age assistance, of Government assistance. This may  
8 be some indication of the income group.

9 MRS. AYLEN: In your care of these patients do  
10 you have any access to funds for drugs or any appliances that  
11 are necessary?

12 MR. KING: Do we pay for drugs?

2 13 MISS MADDAFORD: No, we don't pay for drugs.  
14 I am wondering if you are referring to the home care programs  
15 or to the Victorian Order service?

16 MRS. AYLEN: Home care.

17 MISS MADDAFORD: The home care program in  
18 Ottawa will be providing some drugs and some appliances. There  
19 is a small item in their budget for this. I know that in the  
20 Toronto plan that this type of assistance has been given to  
21 certain patients.

22 MRS. AYLEN: You have some funds to use in that  
23 way?

24 MISS MADDAFORD: Yes.

25 MRS. AYLEN: There was only one other question.



MR. KING: Yes. I don't believe I have the

thing like 45¢ -- well, I am sorry. I am not clear on this.

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are necessary?

MR. KING: Do we pay for drugs?

MISS MADDAFORD: No, we don't pay for drugs.

I am wondering if you are referring to the home care programs

or to the Victorian Order services?

MRS. AYLMER: Home care.

MISS MADDAFORD: The home care program in

Ottawa will be providing some drugs and some appliances. There

is a small item in their budget for this. I know that in the

Toronto plan that this type of assistance has been given to

MRS. AYLMER: You have some funds to use in that

MRS. AYLMER: There was only one other question.





1 I see you have 26 Victorian Order branches with hospital refer-  
2 ral programs. Do you have a resident Victorian Order nurse  
3 in any hospital or simply does she carry out her duties with  
4 the social service part?

5 MISS MADDAFORD: In our hospital referral  
6 programs, if I might answer the question, Mr. Chairman, the  
7 nurse in most of these is on a part-time basis. She will go  
8 in for two hours. It depends on the size of the hospital up  
9 to full-time appointments. She is available to the doctors,  
10 to the head nurses, to anyone in the hospital who would like  
11 to discuss the best care of the patient on her discharge from  
12 the hospital. We don't call them resident.

13 MRS. AYLEN: They are not employed by the  
14 hospital but they are actually working in the hospital?

15 MISS MADDAFORD: That is right. With some it  
16 is a very minimum amount of time. It might be two hours a week,  
17 four hours a week up to half time or even full time basis.

18 MRS. AYLEN: Thank you very much.

19 THE CHAIRMAN: They wouldn't be on the staff  
20 of the hospital?

21 MISS MADDAFORD: I might say here in Ontario that  
22 there isn't any of our branches that receive any type of  
23 payment for this program. In the Montreal plan where they  
24 have their hospital referral program they do receive a payment,  
25 and there is one out west that receives payment. None of the

MISS MADDAFORD: In our hospital referral

MISS MADDAFORD: That is right. With some it

MRS. AYLIN: Thank you very much.

THE CHAIRMAN: They wouldn't be on the staff

MISS MADDAFORD: I might say here in Ontario that

payment for this program. In the Montreal plan where they

and there is one out west that receives payment. None of the



1 plans in Ontario is paid for by the hospital. It is the service  
2 given by the Victorian Order to the hospitals.

3 THE CHAIRMAN: You mentioned a home care plan.  
4 Is this a plan, just for my own information, a plan that is  
5 organized by the Victorian Order of Nurses and operated by them,  
6 and what type of plan is it?

7 MISS MADDAFORD: The only thing that we have  
8 in Ontario is one, the new one we started in Ottawa. It is  
9 a central co-ordination of services necessary to provide adequate  
10 care for patients in the patient's home. That will include the  
11 various services such as home-making services, visiting nursing,  
12 it might include drugs, special appliances, physiotherapy and  
13 social services.

14 THE CHAIRMAN: This is an organization of a group  
15 who are providing this service, not a plan in which the  
16 people who might use the service participate. You don't belong  
17 to this and therefore you get this service.

18 MISS MADDAFORD: No, that is right. It is  
19 a co-ordination of home-care services. For instance in  
20 Toronto, here, this is not sponsored by the Victorian Order but  
21 the patient would be referred for home care and they would  
22 make arrangements with the Victorian Order, make arrangements  
23 with the home-makers or whatever type of service the patient  
24 would require.

25 THE CHAIRMAN: Dr. Butt?





1 plans in Ontario is paid for by the hospital. It is the service

2 given by the Victorian Order to the hospitals.

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15 to this and therefore you get this service.

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17 a co-ordination of home-care services. For instance in

18 make arrangements with the Victorian Order, make arrangements

19 with the home-makers or whatever type of service the patient

20 would require.

21 THE CHAIRMAN: Dr. Elliot?



1 DR. BUTT: If we could pursue this home-care  
2 program a little bit. The hospital referral that you mentioned  
3 first, does this mean they are in a hospital; their office  
4 is in the hospital? I have had a fair amount to do with the  
5 V.O.N. here and there. Some have offices, some don't.

6 MR. KING: If I may answer that as a layman,  
7 what happens is the V.O.N. branch arrange for one of their  
8 nurses to go up to the hospital every week or two, go up an  
9 hour or two a morning and talk to the doctors, advise them what  
10 they can do for patients and ask if they can be of any help.  
11 They will go and talk to some patients. If the doctor decides  
12 to release the patient the Victorian Order will follow through.  
13 They may or may not have a desk et cetera. It depends on what  
14 the hospital can provide for them at the time. It is just a  
15 matter of the nurse going out from the branch to the hospital  
16 for the afternoon.

17 DR. BUTT: Are there any other visiting nurse  
18 organizations that you have worked with? We had representations  
19 from another group. Are you co-ordinated with them in any  
20 shape or form?

21 MISS MADDAFORD: No, we are not.

22 MR. KING: No co-ordination.

23 DR. BUTT: The home-care program you mentioned --  
24 I have a little article here, highlight home-maker program.  
25 It says what we need is a lot of very enthusiastic people. They



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shape or form?

MISS MADDAFORD: No, we are not.

MR. KING: No co-ordination.

DR. BUTT: The home-care program you mentioned --



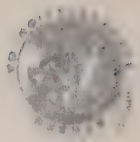


1 go on and itemize the cost of this. Is this the cost you are  
2 referring to? They have physician services on this from 1958  
3 to 1959, a year's physician's services worth \$600, consultation  
4 another \$10 and so on. They get to nursing, home-care and  
5 so on and it is a very large figure to be quite honest. It  
6 comes down to a total of \$9,572. The relative part of it was  
7 \$600 where the physicians service and when you include all the  
8 other necessary services which I believe is what you are talking  
9 about earlier about \$15. Is this really what you are talking  
10 about? If so I want to be clear when you speak of your home-  
11 care program. This is just a quotation I have here.

PE/RPS12 MR. KING: I haven't got the quote here and I would  
13 have to refresh my memory. I thought there was a brief being  
14 presented directly on that, but we haven't dealt with it and  
15 we would certainly be glad to supplement any information that  
16 was given here today, anything you want to know. But when we  
17 are talking about a home-care program, it depends on the extent  
18 of the program. You can have a program that will only permit  
19 the payment of a nurse going in for two hours a day. You could  
20 have a program that would include physiotherapists. You could  
21 have a program that would include a home-maker to look after  
22 the house and to cook the dinner.

23 DR. BUTT: This includes quite a few things?

24 MR. KING: Yes, I know. But this is a very fluid  
25 field.



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1 by on and discuss the cost of that. In only two years the  
2 returning and they have increased services on this from 1965  
3 to 1967, a number of children's services were added, consultation  
4 doctor and so on. They are to be trained, some cases and  
5 so on and it is a very large figure in the total budget. It  
6 comes down to a total of \$5,500. The relative part of it was  
7 \$600 where the physician services and when you include all the  
8 other necessary services which I believe is what you are talking  
9 about earlier about this. In this really what you are talking  
10 about? It is I want to be clear when you speak of your inter-  
11 care program. This is just a provision I have here.

12 MR. KING: I haven't got the quote here and I would  
13 have to refresh my memory. I thought there was a direct being  
14 presented directly to that, but we haven't dealt with it and  
15 we would certainly be glad to supplement any information that  
16 was given here before, depending on what the time. But when we  
17 are talking about a two-way program, it depends upon what  
18 of the program. You can have a program that will only provide  
19 the payment of a nurse going in for the home a day. You could  
20 have a program that would include hospitalization, for example  
21 have a program that would include a community or home visit  
22 the house and to cook the dinner.

23 DR. BUTT: This includes quite a few things.  
24 MR. KING: Yes, I know. But this is a very kind



1 DR. BUTT: My question really is would you be  
2 good enough to table what you feel would be the essence with  
3 regard to your organization. In other words, we can have some  
4 figures as to what this might cost to incorporate your partic-  
5 ular services? Would this be a fair question?

6 MR. KING: I am not quite sure I understand  
7 your question.

8 DR. BUTT: You say we are not going to include  
9 home-makers and all the other things. What would your particular  
10 part . . . ?

11 MR. KING: Our part would be purely nursing.

12 DR. BUTT: Yes. But could you give me some  
13 idea of the figures?

14 MISS MADDAFORD: It has been done on a cost-  
15 per-visit basis. We consulted other organizations, the  
16 Department of Veterans' Affairs and the Metropolitan Life  
17 Insurance Company, and this has been done on a cost-per-visit  
18 basis. It has been worked out quite well and the cost-per-visit  
19 is arrived at on a yearly basis. It is done through a formula  
20 that was worked out by the Public Health in the United States.  
21 It includes all items and expenses and the taking out of  
22 other items that do not pertain to visiting nursing going in,  
23 because we have other programs and we arrived at our cost-per-  
24 visit this way.

25 DR. BUTT: From the insurance companies then, that





DR. BUTT: My question really is would you be

good enough to say what you think of the way the

work is being done? Is it fair to say that the

work is being done in a fair manner?

What services? Would this be a fair question?

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1 do pay you; is that correct?

2 MISS MADDAFORD: Yes, that is right.

3 DR. BUTT: We would be interested in details.

4 MR. KING: I might say, Dr. Butt, that the  
5 average cost-per-visit in Ontario -- this is averaged out for  
6 all nurses throughout the Province, and it varies from branch  
7 to branch and district to district -- for 1960, I think the  
8 last figure we have is for 1962, and our statistics have not  
9 been compiled yet, is \$3.59. And there is a flat fee for a  
10 visit for the nurses at the moment. And this is the cost to  
11 the Order of operating the order throughout the year and making  
12 of calls, occupying the nurse full-time throughout the year --  
13 the average is \$3.59 a visit. Now, whether or not under a  
14 plan, if the nurse had to go into a home for half a day three  
15 days a week, whether you could do it on that basis. But you  
16 can see that, if you look at it that way, if the nurse went  
17 even right now, and the cost is \$3.59 per visit, and sometimes  
18 they might be there now for three hours. It is not so much  
19 compared to the cost of rendering the same service in the hospit-  
20 al, is it?

21 DR. BUTT: I fully appreciate that. But I would  
22 like, if you can give it to us, your projected figures.

23 MR. KING: We would be delighted to help you,  
24 but the Enquiry appreciates, more than we do, that you require  
25 quite a staff to do all this and I am sure that this Enquiry



do pay you; is that correct?

MR. MADHARU: Yes, that is right.

DR. BENT: We would be interested in the data.

MR. KING: I might say, Mr. Bent, that the

average cost-per-vial in Ontario - this is averaged out for

been compiled yet, to \$1.75. And there is a list for a

the order of operating the order throughout the year and making

of calls, covering the whole of the year.

the average is \$3.50 a visit. Now, whether or not under a

plan, if the nurse had to go into a home for half a day, three

days a week, whether you could do it or not. But you

can see that, if you look at it that way, if the nurse went

even right now, and the cost is \$7.50 per visit, and sometimes

they might be there now for three hours. If it was to be

compared to the cost of rendering the same service in the hospital,

is it?

DR. BENT: I fully appreciate that. But I would

like, if you can give it to us, your projected figures.

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but the industry appreciated, more than we do, that you realize

with a staff to do all this and I am sure that this industry





1 and the Government facilities are available for cost analyses  
2 purposes. It is difficult for a voluntary organization to  
3 do all this.

4 DR. BUTT: Our problem is that each person  
5 has brought up a specific item or a group of items of people  
6 they would like to be included, and so on.

7 MR. KING: Yes.

8 DR. BUTT: And they at times give rather vague  
9 reasons of what it would be and I think the group that can  
10 produce their own figures can help us a great deal.

11 MR. KING: I would agree.

12 DR. BUTT: This is all I am asking you. If you  
13 can do it, it would be worthwhile.

14 MR. KING: Surely.

15 DR. BUTT: The only other thing I thought I  
16 would add is that this exemption of the new-born care, well-baby  
17 clinic . . .

18 MR. KING: Yes?

19 DR. BUTT: I think this really has to do with  
20 the fact that the doctor who delivers the baby usually looks  
21 after his immediate post-natal care?

22 MR. KING: Yes.

23 DR. BUTT: And, therefore, this is one fee.

24 So we wanted to make it certain that if there is any exceptional  
25 circumstances, say, then a special fee for that particular item



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1 would be billed for separately so we wouldn't be confused.

2 Do I make myself any clearer?

3 In other words, if a paediatrician has to be  
4 called in for a special thing in the care of that baby, immed-  
5 iately post-natal . . . ?

6 MR. KING: Yes.

7 DR. BUTT: Then they need to be paid for as a  
8 separate item?

9 MR. KING: Yes. But if the doctor delivering  
10 the infant should render any service to the baby . . .

11 DR. BUTT: This is usually included at the time  
12 as part of the obstetrical fee. This is an immediate thing.

13 MR. KING: If that is so and that is all there  
14 is to the problem, why do you need the exception?

15 DR. BUTT: I am not quite sure why, but I am  
16 trying to interpret it for you.

17 MR. KING: And if there should be a fee well,  
18 obviously, it should fall where the other medical fees fall --  
19 that is, cover to cover.

20 THE CHAIRMAN: When you mentioned \$3.59 was the  
21 average cost per call, is that for nursing services only or  
22 that separates the nursing services from the other services that  
23 the Order renders?

24 MISS MADDAFORD: That is just for the visiting  
25 nursing services in a home to a patient. The average cost in





1 would be billed for separately so we wouldn't be confused.

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4 called in for a special thing in the care of that baby, immedi-

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13 MR. KING: Is that he should have it all there?

14 is to the problem, why do you need the exception?

15 DR. BUTT: I am not sure why, but I am

16 MR. KING: And if there should be a fee well,

17 THE CHAIRMAN: When you mentioned \$2.25 was the

18 MISS MADDEN: That is just for the visiting

19 nursing services in a home for a patient. The average cost is



1 Ontario is based on the average cost of each individual branch  
2 that we have in Ontario and some of them are higher than the  
3 \$3.59 and some of them are lower than the \$3.59.

4 THE CHAIRMAN: What other services -- do you  
5 render home-making services, or what other services does the  
6 Order render besides nursing?

7 MISS MADDAFORD: In some branches we are particip-  
8 ating in pre-natal classes. In some branches we have industrial  
9 nursing programs where we go into industry for two or three  
10 hours.

11 THE CHAIRMAN: Well, this would be outside the  
12 home?

13 MISS MADDAFORD: Yes, this would be outside the  
14 home.

15 THE CHAIRMAN: Whenever you go into the home,  
16 that is for nursing only?

17 MISS MADDAFORD: That is right.

18 THE CHAIRMAN: I see. Thank you.

19 MISS MADDAFORD: And at the same time when we  
20 give nursing we try to do some teaching. We teach the patient's  
21 family how to care for the patient in between our visits and,  
22 also, we do some health supervision following our nursing  
23 care visits to them.

24 THE CHAIRMAN: But those you can include in the  
25 nursing services?



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24 care visits to them.  
25 THE CHAIRMAN: But those you can include in the





1 MISS MADDAFORD: Yes. They are really important  
2 to the patients.

3 THE CHAIRMAN: The reason for my question was  
4 I was wondering how you separate it, if you were making calls  
5 for things other than for nursing, how you separate the cost  
2 6 of your call?

7 MISS MADDAFORD: The cost per visit is for all  
8 types of home visits.

9 MR. COULTER: I would like first to compliment  
10 the Victorian Order on the work that they do. I am sure many  
11 people have benefited from it. There are three things that  
12 are bothering me within the confines of the Bill and we are  
13 not here, particularly, to defend the Bill as it now stands.

14 You said, in one place, that the benefits under  
15 the Act be extended to include payment of visiting nursing  
16 services, and so on. I would take it then that you believe,  
17 or the Order would be in favour or remodeling the Bill or a  
18 more comprehensive plan than the Bill 163 now states. You  
19 would be in favour of this?

20 MR. KING: Yes, that is correct.

21 MR. COULTER: Or you would not ask for 1 to 6  
22 to be deleted?

23 MR. KING: That is correct.

24 MR. COULTER: I just wanted to get that in the  
25 record.



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1 MR. KING: That is right.

2 MR. COULTER: In this item 6 of the Bill, there  
3 were one or two questions asked about it but, being a layman  
4 myself and a father--a father so long ago I can't recall whether  
5 I paid the doctor for the first six or seven days or not and,  
6 in your practice, do you find many cases where this is not  
7 covered, the first four or five days is not covered in the fee  
8 of the doctor? This has been bandied around here several times.

9 MISS GOOD: I do not think we have any way of  
10 knowing, sir, just how the doctor is paid. I have no specific  
11 evidence.

12 MR. COULTER: This is the first brief that this  
13 has been in and that it should be deleted from here, and so  
14 forth, and sometime before I finish this questioning, I am  
15 going to find out from somebody.

16 DR. GALLOWAY: From the Ontario Medical Assoc-  
17 iation, sir.

18 MR. COULTER: I will. You also ask for further  
19 development in present branches. Would you expect to get -- I  
20 would imagine in further development you would expect to have  
21 further funds from someplace. Were these public funds that  
22 you are thinking of here?

23 MR. KING: We are just thinking of funds. The  
24 commodity we deal in is service and we struggle from year to  
25 year for funds to pay for these services and it is a real struggle.



MR. KIM: That is right.

MR. COULLEN: In this item 6 of the Bill, there

were one or two questions asked about it but, being a layman myself and a father--a father as long ago I can't recall whether

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1 And if it is decided that people need the service, well then,  
2 the Victorian Order of Nurses' position is that they are  
3 prepared to accept whatever funds are available to pay for that  
4 service and if the people can pay for it directly in terms of  
5 funds, fine. If they can't, well, at the present time in Ontario  
6 we go to the United Appeal for 47%, in 1962 of our funds and  
7 only 18% of the funds came directly from patients.

8 As an illustration of what is happening here,  
9 you are aware that the Homemakers and Nurses' Services Act  
10 provide some funds, which trickle down to the Victorian Order.  
11 In 1952, just in excess of 13% of the total revenue of the  
12 order in the Province came by virtue of that legislation. But  
13 we would think that when the benefits under this legislation  
14 are extended to visiting nurses in the home, that the payment  
15 would be in a similar manner to the payment to a doctor -- would  
16 come from the same source.

17 MR. COULTER: Thank you. You also state on page  
18 1 of your brief, item 2, under (2):

19 "Organization in areas with sufficient  
20 "population and sufficient need to  
21 "warrant the service."

22  
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And if it is decided that people need the service, well then,

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you are aware that the Homecare and Nurses' Services Act

provides some funds, which would be the Victorian Order

In 1952, just in excess of 18% of the total revenue of the

order in the Province came by virtue of that legislation. But

it is not a very large amount, and it is not sufficient to

pay for the service, and it is not sufficient to pay for the

would be in a similar manner to the payment to a doctor -- would

come from the same source.

MR. GOVERNOR: Thank you. You also state on page

"Organization in areas with sufficient

"population and sufficient need to

"warrant the service."





1                   What size of town would this be, or population?  
2   What are you talking about here in number of bodies -- "suffic-  
3   ient population"? Is this 10,000 or 5,000 or 25,000?

4                   MR. KING: We have branches in areas where there  
5   is only four or five thousand people.

6                   MR. COULTER: The question, I think, was  
7   asked whether you were co-ordinated with any other people that  
8   are giving this service. If you are not co-ordinated, is there  
9   an overlapping of the service that you give and the County  
10   Health Unit?

11                  MISS MADDAFORD: The Victorian Order has always  
12   worked on the principle of co-ordinating their services with  
13   other health agencies and we do try, through various means,  
14   to eliminate any overlapping and duplication of services. The  
15   County Health Unit in the areas in which the Victorian Order  
16   is also operating are responsible for the prevention program,  
17   the schools, and the maternity work and home visiting and all  
18   the various programs that they have; and the Victorian Order  
19   is responsible for the nursing care program and any health  
20   instruction that they might give in contact through this type  
21   of program. The means by which we try and eliminate overlapping  
22   is in the maternity field especially because, presumably, we  
23   both do pre-natal, post-natal, and new-born visiting. And we  
24   do try to let the health units know which families we are  
25   visiting. So, this helps to eliminate overlapping of two nurses



What size of town would this be, or population?  
What are you talking about here in number of bodies -- "suffice"  
Same population? Is this 10,000 or 25,000?

MR. KING: We have parcels in areas where there  
is only four or five thousand people.

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are giving this service. If you are not co-ordinated, is there  
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the various programs that they have, and the Victorian Order

is responsible for the nursing care program and any health

instruction that they might give in contact through this type

of program. The means by which we try and eliminate overlapping

is in the nursing field, especially in the home, and in the

work in the schools, and the necessary work and home visiting and all

the various programs that they have, and the Victorian Order

is responsible for the nursing care program and any health



1 going to the same family.

2 MR. COURTER: The reason I asked this was because  
3 you are both sponsored, partially, by public funds and maybe there  
4 should not be an overlapping, if there is, in any particular  
5 case.

6 MR. KING: If I may be permitted to say this:  
7 I think generally the answer is No, there is no overlapping at  
8 all. The Order works pretty well with the public health units  
9 to see that there is no overlapping. As far as any other  
10 volunteer organization is concerned, there is such an enormous  
11 demand for them that there just isn't any overlapping. There  
12 is too much for any of each groups to handle.

13 MR. COULTER: Does the Victorian Order operate  
14 in most of the large cities and large towns, down to 5,000,  
15 across the Province?

16 MR. KING: The order is in every town and city  
17 in Ontario with a population down as low as 10,000, except  
18 two. There are just two towns with a population of ten, or  
19 a little more, where the Order isn't. Every other community  
20 as small as 10,000, there is a branch and there is some in  
21 some communities smaller than ten.

22 MR. COULTER: I was thinking of the outlying  
23 districts and the smaller towns in Northern Ontario, that you  
24 would not be able to service unless funds were made available  
25 so that you could set up the services in those particular areas?





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1 going to the same family.

2 MR. COURTNEY: The reason I asked that was because

3 the first family mentioned, the family mentioned in the

4 would not be so concerned if it were not for the

5 case.

6 MR. KING: If I may be permitted to say this:

7 I think generally the answer is No, there is no overlapping at

8 all. The Order works pretty well with the public health units

9 to see that there is no overlapping. As far as any other

10 volunteer organization is concerned, there is such an enormous

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21 some communities smaller than ten.

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24 would not be able to service unless funds were made available

25 so that you could set up the services in those particular areas?



1 MR.KING: Yes.

2 MR. WHITNEY: How many branches did you say you  
3 had?

4 MR. KING: 57 at the moment.

5 MISS MADDAFORD: And in those 57 branches there  
6 are some urban areas and townships covered as well as a town.

7 MR. COULTER: At the top of page 2:

8 "A prepaid plan for visiting nursing  
9 "could facilitate the early discharge from  
10 "hospital of many patients if the doctor was  
11 "assured of continuing nursing care in the  
12 "home."

13 Does your Order find with doctors expressing  
14 themselves many times that they wished there was more of this  
15 home nursing care?

16 MISS MADDAFORD: I think there is a real feeling  
17 among people that they have their hospitalization paid for  
18 by the hospital scheme, insurance scheme, and there is a tendency  
19 in the thinking that they must be hospitalized because if they  
3 20 were billed for that service in the home, they would have to pay  
21 for that. It is a human factor that enters into this.

22 MR. COULTER: Do you find that the home nursing  
23 care is on the decrease because of hospitalization, rather than  
24 it was before?

25 MISS MADDAFORD: I think in Ontario our nursing



MR. KING: Yes.

MR. WHITNEY: How many branches did you say you

MR. KING: 57 at the moment.

MISS MADDAFORD: And in those 57 branches there

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1 care visits are on the increase and many of our branches are  
2 experiencing increases in our service and particularly is this  
3 true in the group of people over 70, the older-aged group,  
4 that this is where our great field of nursing today is, in the  
5 home, to those long chronic illnesses. And I should not  
6 eliminate the younger people because they too have chronic  
7 illnesses.

8 MR. COULTER: I think that is all I have. Thank  
9 you.

10 MR. WHITNEY: Just to pursue that last point a  
11 little further: from the actual experience of your representative  
12 nurses in the hospitals going there two hours a day or half a  
13 day or a day, whatever time is required, and interviewing  
14 patients who are, according to the doctor, being considered  
15 to be sent out? Have you any practical experience or report  
16 from those nurses that people express themselves against going  
17 out of the hospital because while they are there they are  
18 paid for? Have you had any reports to that effect?

19 MISS MADDAFORD: I really couldn't say that I  
20 have actually had the experience of this happening. I do not  
21 think that I am in a position to know because I am not working  
22 in those plans as closely as I probably should be.

23 MR. KING: Can you add anything, Miss Good?

24 MISS GOOD: I do know, for example, in the Toronto  
25 home-care program nobody leaves the hospital without consenting.



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now that the hospital is in the hands of the government, and  
that this is where our great field of nursing today is, in the  
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MISS MADDAFORD: I really couldn't say that I

MR. KING: Can you add anything, Miss Good?

MISS GOOD: I do know, for example, in the Toronto



1 Nobody is forced to accept the home-care program. It is a  
2 permissive thing but we have noticed this tendency to stay in  
3 the hospital if it is going to be economically difficult for  
4 them to pay for the visit, although we do visit according to  
5 need, rather than according to ability to pay. But many people  
6 would rather stay in the hospital than accept a reduced fee  
7 in the home.

R/RPS 8 MISS MADDAFORD: We do not visit the patients  
9 until the doctor refers the patient to us in hospital. We  
10 don't go around to the patients and suggest a home-care program,  
11 or they are ready for home-care.

12 MR. COULTER: I would not expect that. I am not  
13 bothered about that. I did imagine the doctors would say I  
14 am thinking about discharging this patient. Would you like to  
15 go in and have a chat with her.

16 MISS MADDAFORD: That is the way it happens.

17 MR. COULTER: In the course of the conversation  
18 sometimes a patient might say to the nurse well if I go home  
19 and you have to come out and see me there, it is going to cost  
20 me money. I would rather stay here. If there are any statistics  
21 on that they could be very interesting but if you think it is  
22 only a feeling coming out of your experience, we can leave it  
23 at that.

24 MISS MADDAFORD: That is all it is. We have  
25 no statistics on that point of view.





1 I hope to have the patient in the hospital. It is a  
2 very serious case and we have talked with the doctor about it.  
3 The doctor is in the hospital and we have talked with him about it.  
4 them to pay for the visit, although we do visit according to  
5 the doctor's advice. We have talked with the doctor about it.  
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7 in the hospital.  
8 MISS MADDAFORD: We do not visit the patients  
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25 no statistics on that point of view.



1 MR. COULTER: It is a natural thing, I can  
2 imagine. I don't know to what extent it is there.

3 MR. KING: I inquired on that point. I was  
4 told it is a feeling rather than a statistic.

5 THE CHAIRMAN: Are you finished, Mr. Coulter?

6 MR. COULTER: Yes thank you.

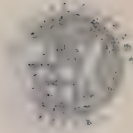
7 THE CHAIRMAN: Mr. Mulrooney?

8 MR. MULROONEY: Thank you Mr. Chairman. The  
9 brief states on page 7, paragraph 21 that you received funds  
10 through municipal and provincial grants. Can you tell us on  
11 what basis these funds are granted by the province and the  
12 municipality?

13 MR. KING: By the municipality?

14 MR. MULROONEY: Or both.

15 MR. KING: Well as far as the municipality is  
16 concerned, for example, we get about 12 per cent of the total.  
17 1962 it cost the Order just over \$2 million to pay for its  
18 operating expenses through that year. 12 per cent of the  
19 funds to meet that came from municipal grants because they  
20 make grants of various funds because some of them have been  
21 doing it, it has been done for years, they are not quite sure  
22 why. In any event, they consider that the Victorian Order  
23 is performing a very useful service and the service which is  
24 performed, a large part of the service is given to elderly  
25 people and to elderly people also who cannot afford to pay for it.



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20 years ago the province paid 10 per cent of the total.

21 doing it, it has been done for years, they are not doing same

22 why. In any event, they consider that the Victorian Order

23 is performing a very useful service and the service which is

24 performed, a large part of the service is given to elderly

25 persons and to elderly persons who are unable to support themselves.





1 They are receiving some form of municipal or government sub-  
2 sistence, like Mothers' Allowance and they feel that on that  
3 basis, if they finance them, they feel on that basis alone they  
4 are justified in making the grant.

5 MR. MULROONEY: It is not calculated then on the  
6 basis of numbers of visits in the particular community or  
7 municipality?

8 MR. KING: No, it is not. If it were done on  
9 that basis, we probably would be getting much more money in  
10 some branches. The home-maker nursing service can account for  
11 another 13 per cent. This is a different legislation, not  
12 for all municipalities. This was a permissive legislation  
13 and not all municipalities have adopted it.

14 MR. MULROONEY: You don't know then from year  
15 to year what the grant will be from the Province or the  
16 Municipality. There is no uniform basis for this sort of  
17 thing.

18 MR. KING: We can never be sure what it is,  
19 no.

20 MR. MULROONEY: Can you state whether these  
21 grants are made because your Order cares for indigent patients  
22 specifically? Or because your services are available to all persons  
23 in the community? The wage-earners, salaried people are paying  
24 the service of members of your Order as well as indigents,  
25 elderly people who are recipients of public assistance?



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1 MR. KING: I think if any one statement was to  
2 be made, I would say that the statement closest to the truth  
3 would be that the municipality are making these grants because  
4 the Order is giving a service to indigents, or people closest  
5 to it.

6 MR. MULROONEY: But the service is generally  
7 available to the people of the community?

8 MISS MADDAFORD: The service is available to  
9 everyone in the community, regardless.

10 MR. KING: That is right but don't forget those  
11 people are people who cannot afford to pay the full fee. There  
12 is no doubt about that. To give you an example of what is  
13 happening, only 18 per cent of the total income is coming from  
14 fees so that very few of the people can pay the full fee.

15 MR. MULROONEY: In the Toronto area what is  
16 regarded as the fee?

17 MISS MADDAFORD: The whole fee? \$4.50.

18 MR. MULROONEY: \$4.50 a day?

19 MISS MADDAFORD: Per visit. That is the fee.

20 MR. MULROONEY: Is this related to the length  
21 of time that the nurse spends in the home?

22 MISS MADDAFORD: In arriving at the fee sir it  
23 is ---

24 MR. KING: It is an average.

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MISS MADDAFORD: It is arrived at between the



1 nurse and the family. They take in the patient's need for  
2 service in arriving at the fee that they can pay.

3 MR. MULROONEY: It is not a uniform fee?

4 MR. KING: Yes.

5 MISS MADDAFORD: The full fee is a uniform fee  
6 but on an individual basis is on a scale basis.

7 MR. MULROONEY: Is there a minimum and maximum?

8 MR. KING: No. There is. The minimum is zero  
9 and the maximum is \$4.50.

10 MR. MULROONEY: That is the maximum fee, \$4.50,  
11 per day?

12 MR. KING: Yes.

13 MISS MADDAFORD: This is the Toronto branch.

14 MISS CARPENTER: Mr. Chairman, may I just add  
15 something? You said \$4.50 per day. I think you mean \$4.50 per  
16 visit and the average length of a visit to a patient who needs  
17 nursing care in the home would be how long?

18 MISS MADDAFORD: Approximately an hour. Depends  
19 on the type of nursing care that we have to give.

20 MISS CARPENTER: Your early statement that a  
21 nurse might be in a home three hours is very unusual. The nurse  
22 who is giving nursing care in the home to a patient would be  
23 about an hour. If the people were able to pay, they would pay  
24 \$4.50?

25 MISS MADDAFORD: That is right, and it might be



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1. What is the fee for a visit to a patient in the home?

2. Is there a charge for the first visit?

3. MR. MURDOCK: It is not a uniform fee.

4. MR. KING: Yes.

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8. MR. KING: No. There is. The minimum is zero.

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1 nursing care would not require the full hour and it would still  
2 be \$4.50 per visit.

3 MISS CARPENTER: In the Toronto branch this is.

4 MISS MADDAFORD: In the Toronto branch.

5 THE CHAIRMAN: Does that complete your questioning?

6 MR. MULROONEY: Yes, thank you.

7 THE CHAIRMAN: Mr. Simon?

8 MR. SIMON: Yes sir, Mr. Chairman. Mr. King  
9 you were asking that the benefits under the Act be extended  
10 to include "payment for visiting nursing services for patients  
11 who the attending physician believes can be adequately cared  
12 for in the home."

13 We assume by that that a nurse's visit to a  
14 patient's home would save a visit by the doctor under these  
15 circumstances? If I would not get the nursing service would I  
16 have to go to a doctor in some circumstances?

17 MR. KING: I don't know. I would say the answer  
18 is this: If the doctor was not going to attend the patient  
19 in the hospital, neither would he attend the patient at the  
20 home on that occasion.

21 MR. SIMON: It is the continuation of the  
22 service?

23 MR. KING: It is the continuation of the service  
24 that was being given in the hospital.

25 MISS MADDAFORD: We only work under a doctor's

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22 service?

23 MR. KING: It is the continuation of the service

24 that was being given in the hospital.

MISS MADDAFORD: We only work under a doctor's



1 orders anyway, and certainly there would be occasions when the  
2 doctor would have to visit because he would certainly want to  
3 check his patient.

4 MR. SIMON: On page 2, item 4, you asked for  
5 the exclusion of these two exceptions, 1 and 6 on schedule A.  
6 Why only these two exceptions? There are other exceptions as  
7 well that are important for patients' care. I could mention  
8 half a dozen of them. We have had quite a few briefs here in  
9 the last couple of weeks. Why does your organization come to  
10 the conclusion that only well-baby care and the other one, annual  
11 examination ---

12 MR. KING: Of course, I am just reading this  
13 now, refreshing my memory since you have asked this question.  
14 We considered it at the time and decided these were the two  
15 most glaring and also in some of these like four, for example,  
16 presumably -- I just cannot answer the question at the moment.

17 THE CHAIRMAN: These actually do step out of  
18 your particular field, to some extent?

19 MR. KING: Yes. I think that is right.

20 THE CHAIRMAN: Just of general interest.

21 MR. SIMON: Are they related to preventive care?

22 MISS MADDAFORD: They are related to preventive  
23 care. I think as a public health agency that we were particularly  
24 interested in these two things.

25 MR. SIMON: I was just curious to know why you said





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check his patient.

MR. SIMON: On page 2, item 4, you asked for

the exclusion of these two exceptions, 1 and 6 on schedule A.

Why only these two exceptions? What are the other exceptions?

Well that are important for the patient care. I really wouldn't

half a dozen of them. We have had quite a few patients here in

the last couple of weeks. Why does your organization come to

the conclusion that only these two exceptions are the most important?

exclusion of

MR. KING: Of course, I am just reading this

now, following my report and the fact that these two exceptions

We considered it at the time and decided these were the two

most important and also the most common of the exceptions.

Interpretation - I mentioned several exceptions, but these two

THE CHAIRMAN: These actually do step out of

your particular field, don't they?

MR. KING: Yes. I think that is right.

THE CHAIRMAN: And the other exceptions?

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1 only those two. Onpage 7 you told us that your services are  
2 being subsidized, to a great extent by public funds and the  
3 service is available, you said before, to anybody and everybody  
4 that is asking for it. I want to be fair with you. This is  
5 a leading question. It leads up to my next question but in  
6 those circumstances why would the public have to pay extra for  
7 service that they are already getting and pay money that is  
8 already available for this very service?

9 MR. KING: I am sorry, I do not quite get the  
10 question.

11 MR. SIMON: Well you say that the Victorian  
12 Order of Nurses is spread out throughout the Province, 75  
2 13 branches and giving the service.

14 MR. KING: That is right.

15 MR. SIMON: Everybody that requires the service  
16 gets it.

17 MR. KING: Yes.

18 MR. SIMON: You also told us that you have means  
19 of meeting your budget, and so on?

20 MR. KING: Yes. Through charity.

21 MR. SIMON: Why would you want to get off that  
22 line and get into the insurance business?

23 MR. KING: Well I don't know whether the Order  
24 is interested in getting off any line. The Order believes that  
25 it can help a scheme in the Province for looking after people's



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1 health and it believes that far more people need help than  
2 are getting it. It sees this when it goes into the poor homes.  
3 It realizes that as far as it is concerned, it finds it  
4 extremely difficult to enlarge its staff. Some of the  
5 branches have been reducing their staff. This last couple of  
6 years one branch cut off staff nurses because they could not  
7 get the revenue to pay their present staff, the operating  
8 expenses. This thing is contracting all the time and the  
9 need is increasing.

10 It is becoming also increasingly difficult for  
11 this type of service to keep convincing people such as the  
12 United Appeal that their funds should be used for this purpose  
13 and this is a problem too, and a real one.

14 MR. SIMON: That is what I wanted you to say.  
15 You did not say it clearly enough in the brief. You made it  
16 much clearer now. I am leading up to the next question. You  
17 suggest that the services be made available to the insurance  
18 plan. Does your organization feel that there would be enough  
19 nurses in the Province to take care of ---

20 MR. KING: No. We do not attempt to approach  
21 it. There are not enough nurses, not enough nurses to staff  
22 the present facilities. What will need to be done in that  
23 regard, some of us may have private views, but I would suggest  
24 to the Enquiry that if we delay the introduction of a plan  
25 until adequate nurses are available to staff it, we will end



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21 it. There are not enough nurses, not enough nurses to staff  
22 the present facilities. What will need to be done in that  
23 regard, some of us may have private views, but I would suggest

24 the difficulty that it is hard for the government to make  
25 really adequate money and available to health care, and will



1 up without nurses or the plan and that we have to prepare the  
2 plan first and then work out a proper scheme to get enough  
3 nurses.

4 MR. SIMON: Maybe you could tell me why there  
5 are not enough nurses in the Province?

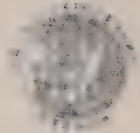
6 MR. KING: Well I don't know. I would suggest  
7 to the Enquiry that a serious look should be taken in this  
8 Province, probably in the country and also many other countries,  
9 particularly in this Province at the moment at the method of  
10 training nurses and it may be that we should start there to  
11 begin with and then having begun there, we should also take  
12 a look at the conditions of employment thereafter and the  
13 remuneration of nurses. I think all this has to be looked at  
14 afresh and it may be a mistake, for example -- I am merely  
15 giving my own view now -- to hold off in the nursing profession  
16 until an apprenticeship method of training nurses that has  
17 been discarded in the legal, my own profession and the  
18 medical profession many years ago, is adopted. This may be  
19 a mistake and it may be another Enquiry is necessary to examine  
20 the condition of nursing education.

21 MR. SIMON: I agree with you.

22 THE CHAIRMAN: Are there any other questions?

23 MR. NAYLOR: If the Act were extended to provide  
24 payment for visiting nursing service, what would you suggest  
25 as the suitable base of payment? So much per visit? Would you





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19 a mistake and it may be another Endury is necessary to examine  
20 the condition of nursing education.  
21 MR. SIMON: I agree with you.  
22 THE CHAIRMAN: Are there any other questions?  
23 MR. MAYLOR: If the Act were extended to provide  
24 payment for visiting nursing services, what would you suggest  
25



1 be able to establish a uniform payment per visit for the  
2 Province?

3 MR. WHITNEY: Or would you set it by area?

4 MR. NAYLOR: And what should it be?

5 MR. KING: Should the cost be?

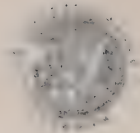
6 MR. NAYLOR: You mentioned \$4.50 in Toronto.

7 MR. KING: We don't know exactly yet how much  
8 you are going to provide and it is pretty difficult to know ---

9 MR. NAYLOR: We don't know either.

10 MR. KING: --- what it should be because if  
11 you had an extremely extensive scheme and nurses may be needed  
12 in the home in some cases 50 per cent of the week as opposed  
13 to five per cent of a week, this is a serious problem which  
14 requires detailed examination on the scheme at the time. I would  
15 think that perhaps that the fees should be based on some sort  
16 of a determined -- on a reasonable basis which may vary. This  
17 pertains to the cost factor.

18 MISS McARTHUR: Mr. Chairman, in relation to  
19 that may I add one question? In relation to private insurance  
20 schemes have you found that such insurance -- I think you have  
21 already mentioned that you do get some visits paid under insur-  
22 ance plans in this Province -- how do you establish your cost  
23 in relation to that and do such plans cover the cost or do  
24 you feel that the Order is still subsidizing through other  
25 methods?



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2 Province?

3 MR. WHITNEY: Or would you set it by area?

4 MR. MAYOR: And what should it be?

5 MR. KING: Should the cost be?

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8 MR. MAYOR: We don't know either.

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15 of a determined -- on a reasonable basis which may vary. This

16 pertains to the cost factor.

17 MISS McARTHUR: Mr. Chairman, in relation to

18 that may I add one question? In relation to private insurance

19 schemes have you found that such insurance -- I think you have

20 already mentioned that you do get some visits paid under them --

21 and plans in this Province -- how do you establish your cost





1                   MISS MADDAFORD: In the schemes whereby the  
2 Department of Veterans' Affairs pay for visits to their people,  
3 that is done on a cost-per-visit basis. They pay the Victorian  
4 Order this year on a provisional rate. When each branch  
5 arrives at their cost per visit for, I will say 1963, because  
6 we have just completed it, they would pay the difference between  
7 the actual cost of making the visit in the individual branch  
8 and the provisional rate. Therefore, in no way do the Victorian  
9 Order subsidize, through the United Appeal or community funds,  
10 recent project visits that they make to this group of patients.  
11 In other insurance plans, some of the group insurance plans that  
12 are available today, and many people seem to have, this is  
13 done usually on a basis of the patient pays the nurse and then  
14 they reclaim from the insurance company and this presents prob-  
15 lems to us because in some families money is difficult to pay  
16 out to the nurse and in most places they have to pay the bill  
17 in order to get the money reimbursed to them and there is prob-  
18 lems in this scheme and certainly it is not done on a cost-per  
19 -visit basis but a fee for the visit and usually your cost per  
20 visit this year, you base your fee on last year's cost so it  
21 could quite easily be in that instance the Victorian Order,  
22 through their community funds, would be subsidizing visits to  
23 patients.

24                   MR. NAYLOR: One small additional question. Do  
25 you feel if the Act were extended to provide the benefits of this



MR. MADDAFORD: In the schemes whereby the

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MR. MAYLOR: One small additional question. Do

you feel if the Act were extended to provide the benefits of



1 service, do you feel it would be practicable to limit it to  
2 cases where the service was needed for health care as opposed  
3 to perhaps helping with household duties or did you get into  
4 that area in your service?

5 MR. KING: The Order does not get into house-  
6 hold service. It does not.

7 MR. NAYLOR: It is purely health care?

8 MR. KING: Yes.

9 MISS MADDAFORD: There are two areas in British  
10 Columbia where we are getting into providing a home-making  
11 service along with the visit. This is a different program  
12 through.

13 THE CHAIRMAN: That is not in Ontario?

14 MISS MADDAFORD: No.

15 MR. NAYLOR: You feel it would be appropriate  
16 then to have payment for all of your services under the Act  
17 where prescribed, where it is recommended by a doctor?

18 MR. KING: Yes.

19 MR. NAYLOR: Or prescribed by a doctor?

20 MR. KING: Yes.

21 MISS CARPENTER: In relation to that last question  
22 where you were introducing the visiting home-maker service,  
23 you have a separate staff to give the housekeeping service?

24 MR. MADDAFORD: That is quite true.

25 MISS CARPENTER: We have gone into a discussion





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service along with the visit. This is a different program

through.

THE CHAIRMAN: That is not in California?

MISS MADDABORD: No.

MR. MAYOR: You feel it would be appropriate

to have a program like that in California?

MR. KING: Yes.

MR. MAYOR: As prescribed by a doctor?

MISS GARNETT: In relation to that last question

where you were introducing the visiting home-maker service,

you have a separate staff to give the housekeeping service?

MR. MADDABORD: That is quite true.

MISS GARNETT: We have gone into a discussion



1 of controlling the mis-use of service. You would have your  
2 control because you only could service when the doctor requests  
3 it but you have other ways of controlling mis-use of service  
4 where the patient would not get more service than they needed.

5 MISS MADDAFORD: Yes. I think the nurse working  
6 in the field, she has discussions with the doctor periodically  
7 and if she finds she is giving daily care and the patient  
8 is reaching the point where he no longer requires daily visits,  
9 then they would change this to space visits and certainly we  
10 do not go on providing nursing care visits to anyone where we  
11 feel the need is not there.

12 MISS CARPENTER: Then you have supervisors I  
13 suppose who help the nurses on this. The other question I have  
14 in mind was this question of the means test. We call up the  
15 problems of how to handle the needy. You mentioned your Home-  
16 maker and Nursing Services Act under which you operate. I assume  
17 that under this Act you have to ask patients to fill out inform-  
18 ation in order to get -- so that the Order will be reimbursed  
19 by Government for the service. Does this create any difficulty  
20 in getting this information from the patients?

21 MISS MADDAFORD: First of all may I go back to  
22 the first. If we go into the home and find the patient isn't  
23 able to pay the full fee the nurse has to get certain information  
24 from the family which includes information regarding their  
25 income, their expenses, and expenses would include their medical



1 of consulting the attending physician. The nurse would  
2 be in the hospital, the nurse would be in the hospital  
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25 income, their expenses, and expenses would include their medical





1 needs, and if they have outstanding accounts, if they have to  
2 use expensive drugs, if they have to have any other help in the  
3 home including home-maker service -- we arrive at a fee with the  
4 patient which they can afford to pay. If it happens in a  
5 municipality where they have the Homemaker and Nursing Service Act  
6 we interpret the Act to the patient and family or to whoever  
7 she is dealing with in arranging the fee. Some municipalities  
8 pay the balance of the fee that the patient is not able to  
9 pay. Then she would say that this could be done through the  
10 welfare of the town and that it would be necessary because this  
11 is welfare legislation for the welfare officer to make a visit,  
12 to fill in their forms which entail very detailed assessment of  
13 income, their assets and everything else in relation to their  
14 financing. This is the only way they will accept a patient for  
15 payment under the Act.

16 MISS CARPENTER: What I am getting at does this  
17 cause the patient distress or are patients so reluctant to  
18 have this kind of visit they don't have the service.

19 MISS MADDAFORD: Sometimes, yes. If the patient  
20 says we don't want to have the welfare officer coming in, we will  
21 not submit to the means test we provide the service and we don't  
22 force them to continue on. In most cases the patients are very  
23 happy to because it is generally the group of people who have  
24 already gone through means tests and receive some kind of  
25 Government assistance.



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22 force them to continue on. In most cases the patients are very  
23 happy to because it is generally the group of people who have  
24 little or no income and they are very grateful for the  
25 Government assistance.



1                   MISS CARPENTER: The other question I had was  
2 in relation to the cost of home care. I read in one of the  
3 briefs that the cost of hospital care in a general hospital  
4 is \$30.20 per day, although you don't have detailed costs of  
5 the care on a daily basis for people in these experimental  
6 home-care plans, do you have an overall estimate of what it  
7 costs? If you don't would you have it from the recent report  
8 on the part of the home-care program in Toronto so that we could  
9 have that information?

10                   MR. KING: We will look into that and see what  
11 we can do.

12                   MISS CARPENTER: Home-making, it is \$5 or \$6  
13 a day. It may even be less than that.

14                   MISS MADDAFORD: We could get that for you.

15                   MR. KING: May I make one comment on the first  
16 question, Miss Carpenter, about our services being based in the  
17 home. The nurses of the Victorian Order are highly trained  
18 people. They are not only nurses which requires a good deal  
19 of training, but they have had post-graduate training and  
20 almost 75% of all the nurses in the Victorian Order are nurses  
21 who not only had the basic nursing course but at least one year  
22 or sometimes two years or more of university training in public  
23 health nursing. We have a highly trained and select group of  
24 nurses, and at your disposal.

25                   THE CHAIRMAN: They may resent washing dishes and





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MISS CARPENTER: Home-making, is it \$2 or \$3

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or sometimes two years or more of university training in public

health nursing. We have a highly trained and select group of

nurses, and at your disposal.

THE CHAIRMAN: They may resent washing dishes and



1 so forth.

2 MR. KING: Yes.

3 THE CHAIRMAN: You are finished, Miss Carpenter?

4 MISS CARPENTER: Yes.

5 THE CHAIRMAN: Mr. Coulter?

6 MR. COULTER: I think you said sometimes in the  
7 case where one of your patients was already covered by an  
8 insurance plan of some type they found they were short of cash  
9 and they paid the nurse and they in turn billed the insurance  
10 company. Is that what you said?

11 MISS MADDAFORD: Yes.

12 MR. COULTER: Why don't the Victorian Order bill  
13 these certain insurance companies for these fees instead of  
14 taking the last dollar because he is honourable enough to give  
15 it to you?

16 MISS MADDAFORD: In some instances we do, but  
17 I think in these particular groups they deal directly with the  
18 patient rather than with the organization and they have to present  
19 the bills. In most instances the Victorian Order branch has  
20 issued bills to the patient, but there is always the question  
21 when the money comes back, if they have a lot of pulls on their  
22 money whether the money would be returned to the Victorian  
23 Order. This involves follow-up visits by the Victorian Order  
24 to collect the fee then.

25 MR. COULTER: I was just wondering if there might



THE CHAIRMAN: You are finished, Miss Carpenter?

THE CHAIRMAN: Mr. Coulter?

MR. COULTER: I think you said somewhere in the

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MISS MADDAFORD: Yes.

MR. COULTER: Why don't the Victorian Order bill

these certain insurance companies for these fees instead of taking the last dollar because he is honorable enough to give it to you?

MISS MADDAFORD: In some instances we do, but

I think in these particular groups they deal directly with the patient rather than with the organization and they have to process the bills. In most instances the Victorian Order branch has issued bills to the patient, but there is always the question of the bill. This involves follow-up visits by the Victorian Order to collect the fee then.

MR. COULTER: I was just wondering if there might





1 be some cases where the billing is covered by insurance and  
2 the patient is reluctant to pay you out of his own pocket  
3 because he is insured. Why wouldn't it be better for you to  
4 bill the insurance company directly and you would be assured  
5 of your fee?

6 MISS MADDAFORD: I think that is the way we  
7 would like it to be done.

8 MR. MAJOR: Have a participating nurse agreement.

9 THE CHAIRMAN: Any further questions?

10 MR. MAJOR: I wonder if you could help me on  
11 a couple of points. On page 1 it states you have classes for  
12 expectant mothers and part-time occupational health service  
13 to small industries. Do you get paid for this work?

14 MISS MADDAFORD: No.

15 MR. KING: Miss Maddaford is the person to  
16 deal with the expectant mother problem.

17 MISS MADDAFORD: Part-time health services, yes,  
18 we do on a fee basis.

19 MR. MAJOR: You are not paid for the classes for  
20 expectant mothers?

21 MISS MADDAFORD: That is a public health service.

22 MR. MAJOR: Do you work in well-baby clinics?

23 MISS MADDAFORD: In some cases, yes, with a  
24 rural base.

25 MR. MAJOR: In some cases?



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3 because he is insured. Why wouldn't it be better for you to  
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11 to small industries. Do you get paid for this work?

12 MR. KEMP: Miss Wadsworth is the person to

13 deal with the expert matter problem.

14 we do on a fee basis.

15 MR. MAJOR: You are not paid for the classes for

16 that is a public health service.

17 MR. MAJOR: Do you work in well-being clinics?

18 In some cases, yes, with a



1 MISS MADDAFORD: Our work in well-baby clinics  
2 is very very minimum today. This is the responsibility of the  
3 health units so that it is only in a few areas that we are  
4 involved in well-baby clinics.

5 MR. MAJOR: You have also stated in answering  
6 a question and on page 10 that you would go into the hospital.  
7 My question really is the costs of these things that are not  
8 being paid, the hospital work and you are not being paid for  
9 clinic work and you arrive at a cost in a branch, for argument's  
10 sake, of \$4 a visit, is this a composite cost you are charging  
11 against the visit? Is your visit cost determined by all the  
12 costs you have got? You have so many visits and you throw  
13 all the costs into the visit and you have so much cost per visit  
14 which isn't actually a cost per visit.

15 MISS MADDAFORD: May I answer that question.  
16 There is a percentage of the cost taken off the total expenses  
17 according to the percentage that is spent in these programs.

18 MR. MAJOR: Is this common to all the branches?

19 MISS MADDAFORD: Yes, it is a formula. It is  
20 worked out and used by every branch. The costs per visit are  
21 computed in the National organization so that there is a uniform  
22 method of computing the cost per visit.

23 MR. MAJOR: You would say that the \$3.59 is  
24 actually the cost of the visit, the time of the nurse or her  
25 car or whatever transportation she required to make this visit?





1 is very very minimum today. This is the responsibility of the  
2 health units so that it is only in a few areas that we are  
3 involved in well-baby clinics.  
4 MR. MAYOR: You have also stated in answering  
5 a question and on page 10 that you would go into the hospital.  
6 My question really is the cost of those things that are not  
7 being paid, the hospital worked you are not being paid for  
8 all the work that you are doing. Is that correct?  
9 MR. MAYOR: Yes, it is. Is that correct?  
10 against the visit? Is your visit cost determined by all the  
11 costs you have got? You have so many visits and you know  
12 all the costs into the visit and you have so much cost per visit  
13 which isn't actually a cost per visit.  
14 MISS MADAM: May I answer that question.  
15 There is a percentage of the cost taken off the total expenses  
16 according to the percentage that is spent in these programs.  
17 MR. MAYOR: Is this common to all the programs?  
18 MISS MADAM: Yes, it is a formula. It is  
19 worked out and used by every branch. The costs per visit are  
20 computed in the National organization so that there is a uniform  
21 method of computing the cost per visit.  
22 MR. MAYOR: You would say that the \$2.50 is  
23 actually the cost of the visit, the time of the nurse or her  
24 car or whatever transportation she required to make this visit?



1 MISS MADDAFORD: That is correct.

2 MR. MAJOR: That is the actual cost of the visit?

3 MISS MADDAFORD: That is right.

4 MR. MAJOR: It doesn't include any hidden  
5 costs related to other visits?

6 MR. KING: The visit does include the cost of  
7 overhead and supervision and everything else.

8 MR. MAJOR: You are not asking the person who  
9 is going to pay you \$4 a visit to subsidize the nurse who is  
10 in the hospital?

11 MISS MADDAFORD: No, it is done on a time  
12 basis.

13 MR. MAJOR: That is fine. I wanted to define  
14 what was in the cost.

15 MISS MADDAFORD: There is one thing I would  
16 like to clarify in the hospital situation. The emphasis is  
17 on home care, we want to make sure we are getting at the  
18 patients that need the service when they go home. We find  
19 when the patient comes home from the hospital and they are  
20 home for maybe two days before they are referred to the  
21 Victorian Order it is after the greatest need for the service  
22 is over. Really the emphasis in hospital referral service  
23 is continuity of nursing care.

24 MR. MAJOR: How many visits can a nurse make  
25 in a day, approximately?



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in the day, approximately?





1 MISS MADDAFORD: This depends on the type of  
2 service that she is involved in each individual call. I would  
3 say she could probably average seven or eight visits.

4 MR. MAJOR: Seven or eight visits.

5 MISS MADDAFORD: If they are long drawn-out calls  
6 it might be less. Isn't that right, Miss Good?

7 MR. MAJOR: Are you acquainted with the terms  
8 deductible or co-insurance, the insurance terms deductible or  
2 9 co-insurance?

10 MR. KING: I am.

11 MR. MAJOR: Would you think it possible that  
12 you could operate your nursing services with this type of  
13 application?

14 MR. KING: It would be possible if somebody  
15 else paid the deductible feature.

16 MR. MAJOR: That is the point I wanted to make:  
17 is it possible for you to collect from the public .50¢ or  
18 \$1 on a visit?

19 MR. KING: The point is that in the co-insurance,  
20 in the deductible features of co-insurance policies, the point  
21 is it doesn't cover the cost of rendering the service and  
22 since it doesn't the Order has to look elsewhere for the  
23 balance.

24 MR. MAJOR: Supposing we assured you you would  
25 get the balance, supposing you were assured you would get the



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MR. MAJOR: Supposing we assumed you would



1 balance?

2 MR. KING: We wouldn't object.

3 MR. MAJOR: Do you think it would be a practical  
4 application if your services were included in some kind of  
5 health rap-up that you could collect the co-insurance feature  
6 of 50¢ or \$1 per visit?

7 MR. KING: Well, I don't know. This would  
8 require consideration, I am sure.

9 MR. MAJOR: Let us turn it around again: you  
10 stated a few minutes ago that you would like to make arrangements  
11 so V.O.N. could get paid directly by some organization or  
12 authority for the visits they made so that the money wouldn't  
13 have to pass through the consumer's hands; is that right?  
14 At that time I made a facetious remark that what you needed was  
15 a participating nurse agreement. Supposing you had this kind  
16 of thing and that all you were expected to do was collect the  
17 base fee of 50¢ or \$1, would this work in your line of  
18 endeavour?

19 MR. KING: The point is, of course, if we are  
20 to collect anything from the patients, most of the patients,  
21 a large percentage of them don't pay anything. The fact is  
22 they can't.

23 MR. MAJOR: They may not be able to pay \$4, but  
24 could you collect 50¢?

25 MR. KING: Today we collect 50¢ when they can pay





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- 1 it. We do it.
- 2 MR. MAJOR: That is all the questions.
- 3 THE CHAIRMAN: Any further questions?
- 4 MR. CASWELL: I would like to ask one thing
- 5 which I believe is apparent. I would like to know from what
- 6 you have said it is costing in the neighbourhood of \$2 million
- 7 to operate and give services through the V.O.N. and you feel
- 8 there are many, many communities that you should go in and
- 9 enlarge your services, therefore I adduce from that if this
- 10 was part of Bill 163 that we could expect the nursing service
- 11 to cost two or three times what it is costing today just
- 12 because of the expansion.
- 13 MR. KING: Well, I would say no. The service
- 14 would not cost more, but more people may be getting more
- 15 service, so we have a larger scheme.
- 16 MR. CASWELL: You see such a need for the
- 17 expansion of services as you answered to my earlier question and
- 18 with two or three times the persons to be serviced, if it was
- 19 included in Bill 163 there is no argument, it couldn't be
- 20 helped, there has to be service to everyone.
- 21 MR. KING: Yes.
- 22 MR. CASWELL: It could very easily cost \$4 million
- 23 or \$6 million.
- 24 MR. KING: Yes.
- 25 MISS CARPENTER: May we ask in that connection



MR. HATCH: That is all the questions.

THE CHAIRMAN: Any further questions?

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was part of Bill 103 that we could expect the nursing service  
to cost two or three times what it is costing today just  
because of the expansion.

MR. KING: Well, I would say no. The service

would not cost more, but more people may be getting more

MR. CASWELL: You see such a need for the

MR. CASWELL: It could very easily cost \$1 million

on \$3 million.

MISS CAMPBELL: May we ask in that connection

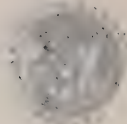




1 if the services of visiting nurses expanded that much would you  
2 assume the cost of hospital care would go down?

3 MR. KING: Well, of course the point we make  
4 is that if some of these services could be given in the home  
5 it should be given in the home. The cost would be less giving  
6 it in the home than in the hospital. If it cost \$4 million  
7 to give it in the home they are still paying \$4 million plus --  
8 I am sorry, I don't have the study made to present to you, but  
9 our point is it would cost \$4 million plus many more millions  
10 to give it in the hospital. That is the point we are making,  
11 and we will endeavour to give you some figures on the cost of  
12 home care to help you.

13 THE CHAIRMAN: This question may have been asked  
14 when I was out. If it was you don't need to answer it. You  
15 have suggested, as you say, the scheme could be expanded to  
16 include payments for a visiting nurse service. You haven't  
17 suggesting how this could be done as to my recollection of what  
18 is in your brief, if it could be done on a fee-for-service, if  
19 it could be done on a per call basis and if it were done on  
20 either one of those bases how should that fee be established.  
21 Could it be the figure of \$3.59 per call? Presumably that is  
22 the total cost per call but of that amount you get something  
23 back in Government grants. You get something back from  
24 municipal grants and you get something back for fees for  
25 service rendered now.



1 to the question of whether or not it is possible to  
2 assume the cost of hospital care would go down?  
3 MR. KING: Well, of course the point we make  
4 is that if some of these services could be given at home  
5 it would be a saving to the Government. The point we are making  
6 is that we know that the Government is not going to  
7 to give it in the home they are still paying \$4 million plus --  
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16 include payments for a visiting nurse service. You haven't  
17 suggested whether or not the Government should be responsible for  
18 the cost of the service. If it is to be a visiting nurse service  
19 it would be paid by the Government. The point we are making  
20 is that we know that the Government is not going to  
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24 to give it in the hospital. That is the point we are making,  
25 and we will endeavor to give you some figures on the cost of  
home care to help you.



1 MR. KING: Yes.

2 THE CHAIRMAN: I would assume if you were to  
3 get \$4 a call you could probably use that additional money to  
4 expand the service further, but still that might be beyond what  
5 is necessary. Is there a possibility that with the experience  
6 that you have had you are in a position to carry your  
7 recommendation further so that you could recommend specific  
8 ways in which, if we were to recommend this it could be  
9 implemented?

10 MR. KING: I don't know what the answer to  
11 that is because in preparing this submission to the Enquiry  
12 we really found that we didn't have time to examine all the  
13 ramifications of this at all. We had to get the brief in,  
14 and this is no fault of anybody's. We didn't have enough time  
15 to do it. Whether we could or not I don't know and how much  
16 effort we need to give to it. We would be prepared to take  
17 a look at the question and see whether we could supply the  
18 Enquiry with additional answers.

19 THE CHAIRMAN: It would seem to me you have  
20 more experience available to you than we have and if you could  
21 provide it -- I realize you are a voluntary organization but  
22 if you could provide us with some of this information I think  
23 it would be of help to us.

24 MR. KING: We would be delighted to re-examine  
25 this and see what we can come up with.



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this and see what we can come up with.



1 THE CHAIRMAN: Do you have any further state-  
2 ments you would like to make?

3 MR. KING: No, that is all.

4 DR. GALLOWAY: If the money were made available  
5 to expand how practical would it be for you to double your  
6 present organization within two years, thinking primarily of  
7 personnel?

8 MR. KING: Well, I think we have the staff to  
9 be able to handle it from an administrative view, adequate  
10 personnel, but whether we could get nurses or not is the problem  
11 and I think a serious question, within a two-year period, I  
12 don't know.

13 DR. GALLOWAY: Do you have any problems getting  
14 personnel now?

15 MR. KING: Yes. We probably would have a very serious problem if  
16 it wasn't for attracting the nurses with scholarships. The  
17 Order in Ontario for example -- from national office funds, the  
18 national office of the Victorian Order last year got 28 scholar-  
19 ship nurses coming into the Order in Ontario. They were provided  
20 with \$1,000 scholarships for them to study at the university  
21 and after graduation they had to come back to the Order. In  
22 addition to that there are at least 20 scholarships of \$1,000  
23 each provided by individual branches, so we have close to  
24 \$50,000 we are providing for university training for nurses on  
25 a post-graduate level. This is the scheme that has enabled the

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1 Victorian Order, I think, to survive with enough staff, and  
2 this would have to be enlarged and other schemes would have  
3 to be introduced.

4 DR. GALLOWAY: Thank you very much, sir.

5 THE CHAIRMAN: Thank you very much.

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2 this would have to be enlarged and other schemes would have  
3 to be introduced.

DR. GALLAGHER: Thank you very much, sir.

THE CHAIRMAN: Thank you very much.



1 SUBMISSION OF THE FACULTIES OF MEDICINE

2 OF:

3 UNIVERSITY OF OTTAWA  
4 QUEEN'S UNIVERSITY  
5 UNIVERSITY OF TORONTO  
6 UNIVERSITY OF WESTERN  
7 ONTARIO

8 Appearances: J.M. Luccier W.H. Allemang  
9 F.R. Chalke O.H. Warwick  
10 E.H. Botterell R.A.H. Kinch  
11 S.L. Vandewater  
12 R.I. Macdonald

13 THE CHAIRMAN: Would your spokesman introduce  
14 himself and then introduce the members of your delegation,  
15 giving their names, initials and positions.

16 DR. WARWICK: Dr. Warwick is my name. My  
17 colleagues are: Dr. E.H. Botterell, Dean, Faculty of Medicine,  
18 Queen's University; Dr. Stuart Vandewater, Professor of  
19 Anaesthesiology, Queen's University; Dr. Allemang, Professor  
20 of Obstetrics and Gynaecology, Faculty of Medicine, University  
21 of Toronto; Dr. Ian Macdonald, Director of the Division of  
22 Postgraduate Medical Education, University of Toronto; Dr. Chalke,  
23 Profession of Psychiatry, University of Ottawa; Dean Lussier,  
24 University of Ottawa and Professor R.A.H. Kinch, Professor of  
25 Obstetrics and Gynaecology at the University of Western Ontario.

26 Mr. Chairman and members of the Committee: The  
27 brief which my colleagues and I present to you today has been  
28 approved by the faculties of the four individual schools of  
29 medicine, representing in all some 1,000 teachers of medicine.





UNIVERSITY OF OTTAWA  
UNIVERSITY OF WESTERN  
ONTARIO

F.R. O'Sullivan  
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17 of Toronto; Dr. Ian MacDonald, Director of the Division of

18 Professor of Psychiatry, University of Ottawa; Dean Innes,

19 University of Ottawa and Professor R.A.H. Kinn, Professor of

20 Mr. Chairman and members of the Committee: The

21 brief which my colleagues and I present to you today has been

22 approved by the faculties of the four individual schools of

23 medicine, representing 18,000 students in medicine



1 The main point, I think, that we wish to make clear is that  
2 the introduction of universal medical coverage will result in  
3 the disappearance of what has been called, or which are called,  
4 public clinic ward or staff patients, those persons who for  
5 years have been an integral and essential part in the teaching  
6 of clinic medicine. To replace the loss of this group, we  
7 propose the establishment of teaching units and we ask, too,  
8 that the teachers of medicine rendering professional services  
9 at those units be remunerated for the giving of such service.  
10 We emphasize too that our schools of medicine are in association  
11 with the affiliated teaching hospitals and are, in essence,  
12 health science centres responsible, among other things, for  
13 the education of personnel, essential to any proposed plan of  
14 medical care, and that such educational responsibilities require  
15 money.

16 Those are the points that we wish to make. I  
17 have read the instructions. I do not intend to read the brief  
18 but, might I have your permission to scan it to emphasize it?

19 THE CHAIRMAN: Yes. And if you feel more  
20 comfortable being seated, do not hesitate to do so.

21 DR. WARWICK: The first page, Mr. Chairman,  
22 points out the responsibilities of schools of medicine in  
23 education extends far beyond the teaching of undergraduate  
24 medical students to the M.D. degree.

25 In addition to this, there is post-graduate



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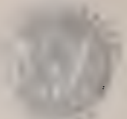


1 education and training of doctors prior to their taking up  
2 the practice of medicine in general, or proceeding to specialists'  
3 degrees, and continuing post-graduate education for medical  
4 practitioners, whether they are general practitioners or  
5 specialists; the education of undergraduate and graduate stud-  
6 ents in basic medical sciences. These are the teachers of  
7 tomorrow, and with all this, an increasing responsibility in  
8 the training of ancillary medical personnel.

9               If there is to be progress in medicine, there  
10 must be research. I think there can be no doubt about the  
11 fact that almost all research in the medical field -- certainly  
12 a very large percentage -- is of the faculties of medicine.  
13 There is the matter of preparation of the personnel to staff  
14 our teaching hospitals and, of course, we must provide  
15 exemplary medical care in our teaching hospitals.

16               There has been great progress in the science  
17 of medical care and if we are to maintain high standards of  
18 quality of patient care and meet these other responsibilities,  
19 we must have an increased number of geographical full-time  
20 and part-time clinical teachers and it is most essential that  
21 we must have sufficient numbers of patients in university  
22 hospitals outdoor and indoor departments consistent with optimal  
23 levels of medical education.

24               I think it is fair to say that we have obstacles,  
25 in terms of lack of funds, at the present time in obtaining the



degrees, and continuing post-graduate education for medical  
practitioners, whether they are general practitioners or  
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ents in basic medical sciences. These are the factors of  
tomorrow, and with all this, an increasing responsibility in  
the training of auxiliary medical personnel.

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in terms of lack of funds, at the present time in obtaining the



1 numbers of staff which are required. We feel that Bill 163  
2 would partly alleviate this problem, in that remuneration to  
3 licensed medical practitioners would be made for medical services  
4 rendered to patients in teaching wards or units, or outdoor  
5 clinics of university hospitals or affiliated hospitals. It  
6 should be emphasized that these patients, at the present time,  
7 are cared for without charge.

8 We feel it would be necessary to continue to  
9 make representations to the appropriate authorities to overcome  
10 the deficiency in resources with which to pay professional  
11 staff for the time devoted to medical teaching, research and  
12 administration. And we feel that it is essential that consider-  
13 ation be given to Bill 163 to ensure that the number of avail-  
14 able patients for teaching in university hospitals should not  
15 be diminished, as the decrease would adversely affect proper  
16 education.

17 Under recommendations we say:

18 "That university teaching hospitals or  
19 "affiliated hospitals should establish clinical  
20 "teaching units, divisions or services, both  
21 "inpatient and outpatient, on the basis recommend-  
22 "ed by the Association of Canadian Medical  
23 "Colleges,  
24 "(2) That medical benefits to patients under any  
25 "major or limited standard plan or prepaid medical





1 numbers of staff which are required. We feel that Bill 163  
2 would partly alleviate this problem, in that remuneration for  
3 licensed medical practitioners would be made for medical services  
4 rendered to patients in teaching wards or units, on a sliding  
5 scale of university hospitals or affiliated hospitals. It  
6 should be emphasized that these patients, at the present time,  
7 are cared for without charge.  
8  
9 We feel it would be necessary to continue to  
10 make representations to the appropriate authorities to overcome  
11 the deficiency in resources with which to pay professional  
12 staff for the time devoted to medical teaching, research and  
13 administration. And we feel that it is essential that consider-  
14 ation be given to Bill 163 to ensure that the number of avail-  
15 able patients for teaching in university hospitals should not  
16 be diminished, as the decrease would adversely affect proper

Under recommendations we say:

- "That university teaching hospitals or  
"affiliated hospitals should establish clinical  
"teaching units, divisions or services, both  
"inpatient and outpatient, on the basis recommend-  
"ed by the Association of Canadian Medical  
"Colleges.  
"(2) That medical benefits to patients under any  
"major or limited standard plan or prepaid medical



1 "insurance should include payments for profession-  
2 "al services rendered by a licensed medical  
3 "practitioner in such designated clinical  
4 "teaching units, services and divisions.

5 "(3) That funds received for the care of patients  
6 "in a teaching unit (in-patient or out-patient)  
7 "should be distributed among the physicians  
8 "participating in the work of the unit in a  
9 "manner to be decided by them in consultation  
10 "with the university, it being understood that  
11 "this type of practice carries with it both  
12 "teaching and research responsibilities.

13 "(4) Recognizing the importance of full-time clinical  
14 "teachers to the faculty of a medical school,  
15 "it is recommended that funds in addition to  
16 "those now available be provided from educational  
17 "sources for the payment of the basic salaries  
18 "of such teachers, according to the proportion  
19 "of their total professional effort devoted to  
20 "teaching, research and administration, approp-  
21 "riate to their position".

22 On the next page we have a definition of a  
23 clinical teaching unit. The remainder of the brief deals with  
24 the details of the recommendations and how they might be  
25 implemented.



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the details of the recommendations and how they might be





1 THE CHAIRMAN: Thank you. Miss McArthur,  
2 you have some questions?

3 MISS McARTHUR: Yes. I read this brief with  
4 very real interest and it seemed to me, on going through it  
5 from beginning to end, I found one very real concern, and that  
6 was this loss of a sufficient number of patients. And I  
7 wondered, from my own profession we have, as a profession,  
8 found ourselves having educational clinical material available,  
9 regardless of whether the payment or non-payment existed. I  
10 also know of one or two examples where the practice of midwifery  
11 or advanced obstetrics was carried forward with private patients  
12 quite happily. And I wondered if there had been any study,  
13 if this was a concern, or was there any real study, any evidence,  
14 that when payment is no longer involved, patients do not make  
15 themselves available for teaching purposes?

16 It seemed to me it came up on the top of page  
17 3 and I found it again back in the supporting material in  
18 (c). Have I made my question clear or very confused?

19 DR. WARWICK: I think there is evidence in other  
20 parts of Canada -- certainly in the United States -- to the effect  
21 that so-called private or semi-private patients or patients  
22 not covered otherwise, do become available for teaching purposes  
23 and that there is not a problem in this regard.

24 MISS McARTHUR: This is my feeling. But it  
25 seemed to me your brief was saying there was a problem. You had



1 You have some questions?

2 MR. McANULTY: Yes. I read this in it with

3 very real interest and it seemed to me, on going through it  
4 from beginning to end, I found one very real concern, and that

5 was this loss of a sufficient number of patients. And I

6 wondered, from my own profession we have, as a profession,

7 found ourselves having educational clinical material available,

8 regardless of whether the payment or non-payment existed. I

9 also know of one or two examples where the price of a study

10 or advanced education was carried forward with private patients

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12 if this was a concern, or was there any real study, any evidence

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21 not covered otherwise, do become available for teaching purposes

22 and that there is not a problem in this regard.

23 MISS McANULTY: This is my feeling. But it

24 seemed to me your brief was saying there was a problem. You had



1 a fear of a problem being created.

2 DR. WARWICK: The point is that we have what  
3 might be called teaching units now. These are public wards.  
4 This is the way it has been for years and in this Province the  
5 introduction of a universal plan will create a distinct change  
6 which must be met by making new arrangements.

7 MISS McARTHUR: So really you are emphasizing  
8 the point that new thinking, new arrangements, new interpretation  
9 in order that clinical material will be available is what you  
10 are desiring, rather than saying that it may not be available?

11 DR. WARWICK: We feel that if teaching units  
12 are established that patients will be available.

13 MISS McARTHUR: But it needs to be organized?

14 DR. WARWICK: Yes.

15 MISS McARTHUR: Thank you, Mr. Chairman. That  
16 is all right now. I may have some questions later on.

17 DR. GALLOWAY: Dr. Warwick, one of the things  
18 that interested me in your brief, and we are as sympathetic  
19 to your problems as we can be, is that it should be divided  
20 into two parts -- outpatients and inpatients. The problem that  
21 you did arrive at was in those hospitals that did not have  
22 fully-controlled public wards, people became eligible in  
23 semi-private accommodations in hospital. So it really was  
24 more the hospitalization for in-patients that created your  
25 problem. But in the outpatient department, the situation seems





DR. WARWICK: The point is that we have what

might be called teaching units now. These are public wards.

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1 to be different and if you take the fact that 65 to 70 per cent  
2 of people are now insured for medical care and somewhere between  
3 20 and 30 per cent of the people who are covered either by  
4 medical welfare plans or just do not have any insurance, it  
5 is from this little group that your out-patient department has  
6 been built up. People with medical welfare form a very large  
7 percentage of those. And, yet, over the years those people  
8 have elected to attend your out-patient department clinics  
9 and to bypass their general practitioners. What is there about  
10 the change that will concern you?

11 DR. WARWICK: Dr. Galloway, I think there are  
12 some doctors who feel that the introduction of a plan such as  
13 this may mean the end of out-patient departments. There are  
14 others who feel, and I have talked with doctors in general  
15 practice, who say that they feel that this will not be the  
16 case, that the patients will continue to come. But I am not  
17 sure of the question you are asking. Do you feel that there  
18 is a danger or that there is no danger?

19 DR. GALLOWAY: I can't see how there can be  
20 any great danger as far as the out-patient department is con-  
21 cerned, because a great majority of your patients are already  
22 insured through the Ontario Medical Welfare Plan. They have  
23 the same right to go to a general practitioner with this plan  
24 as they will have with any other re-arrangement of insurance.  
25 And what would drive them from your place into the hands of a



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1 general practitioner, where they have been bypassing the  
2 general practitioner over the years?

3 DR. WARWICK: The point is well taken and I  
4 hope it is true.

5 DR. GALLOWAY: I hope it is, too. I am going  
6 to ask some questions because we are going to have to sit  
7 down subsequently and discuss these things and some of them  
8 I know the answers to and some of them will be for the education  
9 of the Committee. The word "geographical full-time teaching",  
10 as you have described on the first page, would you explain  
11 exactly what you mean by that?

12 DR. WARWICK: These are members of the university  
13 staff, clinical staff, working in hospitals who, by our  
14 definition at our university, and I think it is the same as the  
15 others, are geographical full-time in the sense that they have  
16 their office in the hospital and they spend all of their working  
17 day in the hospital, administrating, supervising work in the  
18 public wards and, in addition, having a referred practice. Is  
19 this satisfactory?

20 DR. GALLOWAY: Yes, I think so. In other words,  
21 those people are receiving income from two separate sources?

22 DR. WARWICK: They receive part of their income  
23 from the university for their teaching and research responsibilities  
24 and another part of their income from a referred practice.

25 DR. GALLOWAY: The work that they do on the public



General practitioner, where they have been practicing the  
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DR. GALLOWAY: The work that they do on the public



1 wards and which they are not paid for at the present time, is  
2 remuneration you wish to receive for them to attract more and  
3 better people for this type of teaching?

4 DR. WARWICK: We feel that the hard core of  
5 geographical full-time workers should be strengthened.

6 DR. GALLOWAY: Can we come down to the practical  
7 point in what is going to happen to the patients who are now  
8 having their care fully paid for. I am sure you are aware that  
9 there is approximately 700,000 visits to the out-patient  
10 departments in a year in hospital. What happens to the patient  
11 who walks in off the street and goes to the emergency depart-  
12 ment and is subsequently referred by the interne who sees  
13 him, or the staff man who is in charge, to the man on call  
14 that day, or whether he would be referred to the clinic? From  
15 a practical standpoint, what type of payment do you anticipate  
16 should be given to the next doctor that sees that patient?

17 DR. WARWICK: Mr. Chairman, one of the persons  
18 with us, who has a great deal of interest in this is Dr. Allemang.

19 DR. ALLEMANG: Dr. Galloway, would you mind  
20 just repeating this problem of the matter of referral. Is  
21 this the question that arises in your mind: How will remuneration  
22 be made in referral?

23 DR. GALLOWAY: Yes. My concern, Dr. Allemang  
24 is to try and see a practical method as far as the insurance  
25 agencies are concerned, as to what they may expect with the





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a practical standpoint, what type of payment do you anticipate

should be given to the next doctor that sees that patient?

DR. WARWICK: Mr. Chairman, one of the persons

with us, who has a great deal of interest in this is Dr. Allerman.

DR. ALLEMAN: Dr. Galloway, would you mind

just repeating this problem of the matter of referral. Is

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agencies are concerned, as to what they may expect with the



1 inter-departmental referrals. I am really trying to trace  
2 a patient who walks in off the street to a teaching hospital.

3 DR. ALLEMANG: I feel that we have anticipated  
4 this and what we would recommend would be that there be  
5 payment only for necessary medical services, as would exist  
6 in private practice where the patient is seen under the same  
7 circumstances. That is, the ultimate doctor who is responsible  
8 for the care of this patient, we would recommend be remunerated  
9 as any other doctor necessarily would be.

10 The cases that come to a university teaching  
11 hospitals frequently present complications or bizarre or unusual  
12 cases to a degree greater than seen in private practice, perhaps.

3 13 Our recommendation, in respect of the payment for referrals,  
14 as far as the insurance companies are concerned, would be that  
15 they would be limited to necessary referral -- that this  
16 requires some definition. We would require where we are  
17 dealing with a patient with multiple complexities and problems,  
18 that necessary consultation should be remunerated. That is,  
19 if the patient has suffered, for example, a serious injury  
20 in a motor accident, it may be necessary to require consultation  
21 from the orthopaedic surgeon, from the neuro-surgeon; one  
22 might even require an internist, in certain circumstances, and  
23 where these are regarded as necessary, we would expect them to  
24 be remunerated just as they would be in private practice.

25 On the other hand, where there are circumstances



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1 arising in a particular case that is of unusual interest, that  
2 may be extremely useful for teaching, we would not expect any  
3 remuneration. Moreover, we feel that one consultation with  
4 a specialty should be sufficient. We think that a specialist  
5 within his field, as recognized by the Royal College, should  
6 be sufficient in respect to a particular specialist consultation;  
7 however, we are well-aware that our confreres on our own staff  
8 will, of course, have intra-departmental consultations, from  
9 time to time; however, we do not expect that insurance necessarily  
10 should pay for these. So that, briefly, we expect that it  
11 should apply as any other situation.

12 DR. GALLOWAY: This same situation would exist  
13 then in the out-patient department?

14 DR. ALLEMANG: Yes. We have presented some  
15 suggestion in respect to out-patient departments. We realize  
16 that for teaching purposes that certain clinics are held there  
17 that may be well conducted at what we would call the levels of  
18 practice in general. For example, in obstetrics and gynaecology,  
19 we like to get a certain number of normal cases in these units  
20 for teaching purposes. We do not expect to be remunerated for  
21 these at a specialist fee, nor do we expect that there will be  
22 a consultation fee by specialists. And the same would apply  
23 in other non-specialist clinics. This should be maintained for  
24 undergraduate education and this is what we hope to do, without  
25 an excessive charge for maintaining.



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1 DR. GALLOWAY: Do you have any approximate --  
2 I am sure you have a very accurate -- idea of the number of  
3 obstetrical cases that are dealt with in the public wards of  
4 your hospital?

5 DR. ALLEMANG: Yes. We have a fairly constant  
6 figure, varying slightly from year to year; but it runs about  
7 1,200 cases per year at our own hospital.

8 DR. GALLOWAY: This would be financial remuneration  
9 for the man in charge of that department at that  
10 particular time?

11 DR. ALLEMANG: Presumably to the associated staff  
12 in that department.

13 DR. GALLOWAY: The only other question is that  
14 I notice in your costs of running an out-patient department  
15 there was a considerable amount, roughly \$170,000, I think it  
16 was, for the laboratory work in the out-patient department.  
17 This department, undoubtedly, is controlled by a physician at  
18 the top and would this laboratory work also become a separate  
19 charge?

20 DR. ALLEMANG: I do not know that I can answer  
21 that. We may have some help from our medical confreres on that.

22 DR. MACDONALD: I do not think I can answer that,  
23 Dr. Galloway, although, on the numbers in our out-patient depart-  
24 ment, a figure of \$170,000 does not seem too great to deal with  
25 the ordinary and necessary laboratory procedures in that type





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DR. GALLOWAY: Do you have any approximate --

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DR. ALLEMAN: Presumably to the associated salary

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DR. GALLOWAY: The only other question is that

I notice in your costs of running an out-patient department  
there was a considerable amount, roughly \$10,000. I think it  
was, for the laboratory work in the out-patient department.

This department, undoubtedly, is controlled by a physician at  
the top and would this laboratory work also become a separate  
charge?

DR. ALLEMAN: I do not know that I can answer

that. We may have some help from our medical colleagues on that.

DR. MACDONALD: I do not think I can answer that.

a figure of \$10,000 does not seem too great to deal with



1 of practice. In other words, I do not believe that that figure  
2 represents a lot of work done because of teaching interests.  
3 I think it represents a practical interest. I haven't been  
4 working in the out-patient department for a few years; but that  
5 was the way it ran before and I think it runs the same way  
6 now.

7 DR. GALLOWAY: My reason for asking this was  
8 that in-patient diagnostic care is paid for in the Ontario  
9 Hospital Services at the present time, but out-patient  
10 diagnostic care is not and this can, across the Province, run  
11 into a very considerable sum of money.

12 DR. MACDONALD: I think, Dr. Galloway, these  
13 are the patients coming to an out-patient clinic, particularly,  
14 and a university hospital must have what we choose to call  
15 exemplary care and there are certain laboratory procedures which  
16 are absolutely necessary to give them that care. And I would  
17 think that it would be very difficult to put it below the  
18 figure that you have mentioned, and it might rise particularly  
19 if the people at the top that you mentioned did not constantly  
20 insist on proper laboratory tests being applied at the proper  
21 time.

MR/RPS 22 DR. GALLOWAY: Thank you very much.

23 THE CHAIRMAN: I refer to one of the questions  
24 that was asked by Dr. Galloway here relative to the physician  
25 who is on the staff teaching, the university teaching hospital,



of practice. In other words, I do not believe that that figure represents a lot of work done because of teaching interests. I think it represents a professional interest. I think it was the way it was before and I think it runs the same way.

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MR. MACDONALD: I think, Dr. Galloway, these are the patients coming to an out-patient clinic, particularly, and a university hospital must have what we choose to call are absolutely necessary to give them that care. And I would think that it would be very difficult to put it below the figure that you have mentioned, and it might rise particularly if the people at the top that you mentioned did not constantly insist on proper laboratory tests being applied at the proper time.

DR. GALLOWAY: Thank you very much.

THE CHAIRMAN: I refer to one of the questions that was asked by Dr. Galloway here relative to the physician





1 practising on a referral basis and receiving salary from a  
2 university is it or the hospital university?

3 DR. WARWICK: University.

4 THE CHAIRMAN: And receives fees for service  
5 on a referral basis. Could he refer patients to himself?

6 DR. WARWICK: No sir. I should have mentioned  
7 too sir that the geographic full-time personnel of this kind,  
8 there is a limitation of income.

9 THE CHAIRMAN: Mr. Major?

10 MR. MAJOR: Gentlemen, I am pretty confused so  
11 if you can straighten me out then you can straighten the  
12 Committee out. On page 10, paragraph 4:

13 " . . . no university clinical teacher  
14 "can receive reimbursement through the university  
15 "for patient care."

16 I gather, of course, that if you are going to  
17 teach you have to have teaching material; that this patient  
18 care that you are speaking of on this page is outside the scope  
19 of the teachers in relationship to the university. Is that  
20 correct?

21 DR. WARWICK: Yes sir.

22 MR. MAJOR: In other words, this is private  
23 practice?

24 DR. WARWICK: Yes sir.

25 MR. MAJOR: Now I gather Dr. Warwick, from your



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DR. WARWICK: University.

THE CHAIRMAN: And receives fees for service

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of the teachers in relationship to the university. Is that

correct?

DR. WARWICK: Yes sir.

MR. MAJOR: In other words, this is private

MR. MAJOR: Now I gather Dr. Warwick, from your



1 introduction, that your main problem here is to find enough  
2 money to pay the teaching staff so that you can get enough  
3 teachers to try to keep up with the apparent future demand  
4 of physicians. Now to me it seems that there is a deviation  
5 from a norm here, a branching of the program where you feel  
6 it is necessary for you to set up some kind of an organization  
7 to obtain money through insurance organizations, through the  
8 insurance subscribers when it looks to me as if this money  
9 should be paid by the school that is hiring you to teach these  
10 things.

11 DR. WARWICK: This is exactly how we feel sir.  
12 We would prefer, in the last recommendation -- this is a  
13 statement that is made sir:

14 " . . . that funds in addition to those  
15 "now available be provided from educational  
16 "sources for the payment of the basic salaries  
17 "of such teachers . . ."

18 This is where we would prefer to see the  
19 additional monies come from, whether it is from the new depart-  
20 ment of the university but at least coming to us in what we  
21 call hard money, university salaries.

22 MR. MAJOR: Do I understand you want this money  
23 to come from the public through insurance organizations?

24 DR. WARWICK: No sir.

25 MR. MAJOR: You want it to come from the university?



introduction, that your main problem here is to find enough money to pay the teaching staff so that you can get enough teachers to try to keep up with the apparent future demand of physicians. Now to me it seems that there is a deviation from a norm here, a branching of the program where you feel it is necessary for you to set up some kind of an organization to obtain money through insurance organizations, through the insurance subscribers when it looks to me as if this money should be paid by the school that is hiring you to teach these things.

DR. WARWICK: This is exactly how we feel sir.

We would prefer, in the last recommendation -- this is a

"... that funds in addition to those

"sources for the payment of the basic salaries

"of such teachers . . ."

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ment of the university but at least coming to us in what we

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1 DR. WARWICK: Yes.

2 MR. MAJOR: This is the place it should come  
3 from?

4 DR. WARWICK: Yes sir. May I ask Dr. Luccier  
5 to speak?

6 THE CHAIRMAN: Feel free to call on any member  
7 of the delegation Dean.

8 DR. LUSSIER: Continue your question please.

9 MR. MAJOR: Now you will have to bear with me  
10 because I am trying to get this straightened out in my mind.  
11 I have before me here the university salaries for the year  
12 1962/63 and the medium salary for biological sciences and else-  
13 where, here it breaks this down into applied biological sciences  
14 to faculties of medicine -- I am using this one because it  
15 sets forth mediums -- and a professor in 1962, 1963, the medium  
16 for professors in biological science was \$13,226. To me, as  
17 a layman, a teacher in the university -- I might add the  
18 associate professor is \$10,344 and the assistant professor  
19 is \$8,220. Are you trying to augment this salary or is there  
20 somebody teaching in the university that does not get paid this  
21 salary?

22 DR. LUCCIER: I am pretty sure sir the figures  
23 that you have quoted there refer to so-called basic science  
24 full-time professors on the campus. I am pretty sure the  
25 salary you have quoted there is correct.

DR. WARRICK: Yes.

MR. MALOR: This is the place it should come.

DR. WARRICK: Yes sir. May I ask Dr. Lussier

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1 MR. MAJOR: In other words, it is salary?

2 DR. LUCCIER: Professor of anatomy, for instance  
3 or professor of biology.

4 MR. MAJOR: And it is equivalent to this  
5 georgraphic full-time man?

6 DR. LUCCIER: Well the full-time is an entirely  
7 new type of word. It only recently has come up. In the old  
8 times, of course, the professor of medicine was not paid at  
9 all. He was the senior surgeon, or the senior physician in  
10 the hospital and he was earning his money through private practice.  
11 Now in Canada it is only since the war that we have introduced  
12 the geographic full-time man. Of course, you cannot attract  
13 the physician or the surgeon at the same sort of salary, \$13,000  
14 so he is paid that amount of money, or roughly the same by  
15 the university for just his teaching duties, not to look after  
16 the patients.

17 Also, the university does not want to be involved  
18 in practising medicine so what he does, what he has been doing  
19 is treating the patient on the ward free or through referral  
20 practice or private patients within the hospital. If our  
21 full-time teachers are not in a position to earn some money in  
22 practising medicine in the hospital -- in other words, not really  
23 treating the patient on the ward free, but to be paid for  
24 services rendered to the patient, then it becomes a problem  
25 to more and more people but the university still have a problem



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1 to find the initial \$13,000 to pay these people.

2                   Until recently the Faculty of Medicine, this  
3 was a four-year course so the president of the university was  
4 very happy because he was receiving the fees from four years  
5 of students paying salaries only the first two years of the  
6 professor; last two years not getting paid. Now the university  
7 presidents are quite alarmed to see that we have to pay clinical  
8 people and the university still has to find the money to pay  
9 the initial basic salary for teachers.

10                   Also we must assure these people, these doctors,  
11 these professors, they have enough referral practice to earn  
12 the difference to have the same income as the general practitioner.

13                   MR. MAJOR: How much would that difference be?

14                   DR. LUCCIER: It varies.

15                   MR. MAJOR: Just relative terms.

16                   DR. LUCCIER: We usually put a time limit on  
17 referral practice, either in terms of time or in earning a  
18 salary. I would say that around, between--anywhere between  
19 \$20,000 and \$30,000 is the combined incomes of full-time men,  
20 senior men.

21                   MR. MAJOR: I have got to get this down to  
22 some facts I can understand. You will see what I am heading  
23 for in a second. I don't want to tell you yet. Supposing that --  
24 we have no orthopaedics. We will take an orthopaedic specialist.  
25 An orthopaedic specialist gets an appointment to a hospital as a





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1 professor, or assistant professor but he has a private practice  
2 and he teaches in this hospital. I don't want to involve  
3 the salaried physician in the hospital. You call them the  
4 residents. I want to go on and involve this man who is  
5 responsible for teaching orthopaedics.

6 Now would you feel free to make a guess at what  
7 the average professor, not full-time, not geographic, there  
8 all the time, would be paid by that university for his job  
9 and how much time he might spend a year?

10 DR. BOTTERELL: Mr. Chairman, I can answer that.  
11 I am not an orthopaedic surgeon. I was a neurological surgeon  
12 until a year and a half ago. My annual salary was \$350.

13 MR. MAJOR: And the time you spent teaching?

14 DR. BOTTERELL: Clinical teaching, didactic  
15 teaching and research, and administration appropriate to my  
16 job in terms of hospital university -- one only can guess the  
17 actual teaching hours -- whom am I teaching? Your question has  
18 to be extended. I am teaching undergraduates. I am teaching  
19 internes, residents. I took part in teaching the nurses in the  
20 neurological unit. I teach occupational physiotherapist students,  
21 not so much when I got to be the head of the unit but still  
22 some. I took part in the graduate teaching of physiatrists,  
23 rehabilitation medicine doctors who have an interest in assoc-  
24 iated university hospital, Lyndhurst Lodge.

25 I took part in teaching speech therapists in one



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position. I would estimate that I would have spent about

17 percent of my time in teaching. I would have spent about

18 to be extended. I am teaching undergraduates. I am teaching

internes, residents. I took part in teaching the nurses in

neurological units. I have been involved in administrative work

and in the past I have been involved in research.

Rehabilitation medicine doctors who have an interest in associ-

ated with the medical profession.

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1 particular session and nurses both on the unit and for the  
2 unit. How one breaks that all down into teaching undergraduate  
3 teaching, which is what Dr. Luccier is talking about paying  
4 for I think is strictly interpretation in the medical budget.  
5 I suppose it would work out to perhaps two days a week if you  
6 took it all in, all the pieces and Dean Hamilton on your  
7 Committee sir has gone into this more recently than I have.

8 THE CHAIRMAN: If you think Dean Hamilton would  
9 be able to give an answer to that, I wish you would feel free  
10 to do so.

11 DR. HAMILTON: I think Dr. Botterell has given  
12 a very good estimate, two days a week if we take a six-day week.  
13 Most clinicians work six and a half days. Of the various  
14 people I have talked to, some 160, the amount of time varied  
15 from two to three days per week. Up to 50% of the individual's  
16 time is devoted to teaching in its broadest aspects and the  
17 administration thereof and payment, it was purely nominal in  
2 18 terms of honorarium, two or three hundred dollars. There is a  
19 variation depending upon the status of the individual in the  
20 hospital and the stage of his own development from a few hours  
21 per week ---

22 DR. WARWICK: Mr. Chairman, I think it is fair  
23 to say further to what Dr. Hamilton said that very seldom is  
24 the teaching responsibility less than four hours a week.

25 THE CHAIRMAN: Would you pardon a question which is



teaching, which is what Dr. Incester is talking about paying  
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Committee at that point with regard to what I said.  
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DR. WATKINS: Mr. Chairman, I think it is fair

THE CHAIRMAN: Would you pardon a question which I



1 on your question. How do you distinguish between the full-time  
2 and the part-time teacher under these circumstances?

3 DR. WARWICK: A full-time teacher sir has his  
4 office in the teaching hospital. A part-time teacher has his  
5 office outside. That is one distinction.

6 THE CHAIRMAN: As Dr. Botterell said you were  
7 receiving \$350 a year. Was that the remuneration for your  
8 teaching work? Well this would be on a part-time basis?

9 DR. WARWICK: Yes sir.

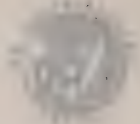
10 THE CHAIRMAN: Where it is on a full-time basis,  
11 the salaries are more in line with the regular faculty schedule  
12 of salaries?

13 DR. WARWICK: Yes sir.

14 MR. MAJOR: Gentlemen, we have arrived at the  
15 point here where we have a teacher giving approximately, we  
16 will say for the sake of argument, 600 hours of his time a year  
17 in teaching for something less than \$1 an hour. Are these  
18 the people that you are trying to find money for? Are these  
19 the people that you wish to allow the privilege of charging if  
20 the person is covered by insurance?

21 DR. WARWICK: I might answer that. I think it  
22 is the feeling of all of us that the doctors who do give of  
23 their time, and so much of it as part-time teachers, may receive  
24 more than an honorarium for the time they are devoting to  
25 teaching but our great need, in addition, is to increase the number





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THE CHAIRMAN: Where it is on a full-time basis, the salaries are more in line with the regular faculty salaries of salaries?

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1 of geographic full-time teachers because teaching clinical  
2 medicine, Great Britain, United States and other countries and  
3 it is since beginning here, there is more need for more personal  
4 supervision of the students on the wards.

5 MR. MAJOR: In the past the insurance industry  
6 in the prepaid movement has been up against the problem of the  
7 Dr. Botterells who spends six hours of their time a year  
8 teaching and only have another 1,000 or 1,400 or 1,600 hours  
9 to make a living. They, therefore, have to charge a fee which  
10 has been over and above the normal schedule that would usually  
11 be charged. Is this correct, by and large?

12 DR. BOTTERELL: I cannot answer that question,  
13 Mr. Chairman, by and large. I think Mr. Major could answer  
14 it better than I can.

15 MR. MAJOR: I think I have the answer.

16 DR. BOTTERELL: The answer is I was participating  
17 physician in P.S.I. and most of my colleagues were and as far  
18 as I know, extra billing was not a very great problem with  
19 people who were doing teaching.

20 MR. MAJOR: It was not a big problem but it was  
21 a problem. Now I would like to come to the point where I would  
22 like to understand why you want to use the method you have  
23 suggested here to get this money, rather than go back to the  
24 employer and say to him that for 600 hours of teaching a year  
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MR. MAJOR: It was not a big problem but it was a problem. Now I would like to come to the point where I would like to understand why you want to use the method you have suggested here to get this money, rather than go back to the employer and say to him that you 600 hours of teaching a year you should pay X number of dollars.





1 DR. HAMILTON: Mr. Chairman, I think there has  
2 been a misunderstanding between Mr. Major and the people answer-  
3 ing the question. I do not think they quite understood his  
4 question, to the effect that -- or at least it sounds as if  
5 Mr. Major is asking why you want the insurance companies to  
6 pay for teaching. Is this what you are asking? Are you  
7 asking for the insurance companies to pay the cost of teaching?

8 DR. LUCCIER: Not at all sir. I thought I made  
9 -- I tried to make the point in saying the universities still  
10 have the problem to find the money for the basic salary, this  
11 \$13,000 they want to give the professor, a person from the  
12 university, for his teaching duties, for the number of hours  
13 that Dr. Botterell spent, put into the teaching activity.  
14 Instead of being paid by the university \$250, he will be paid  
15 \$13,000 by the university for that particular purpose. But  
16 this still does not solve the problem, because we do not want  
17 that man, Dr. Botterell, to go and earn his living in private  
18 practice out of the hospital. We want a nucleus of men who  
19 will have their office in there; will not have private patients  
20 in the sense of a patient would come direct to him and when  
21 he has any free time will come to the hospital and look after  
22 the students on the ward. We want a man there all the time.

23 With this new type of medical education, we are  
24 faced with the problem and, therefore, we want teachers who have  
25 been divorced from general practice in the sense they are not



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1 or will not go out and earn a living from their own private  
2 patients in their own office. They are in the hospital. They  
3 are paid \$13,000 by the university. Obviously that is not  
4 enough. Now if it is not enough, and you are on the ward  
5 looking after teaching, looking after the patient, he cannot  
6 look after them free now because it is his only source of  
7 income. He must be paid for the service that he is giving to  
8 the patient because that will be practically his own patient.

9 MR. MAJOR: My only comment doctor is that pays  
10 him \$25,000 and not \$13,000. Let me take a couple of jumps  
11 ahead. This is a large province and there is, I feel, a  
12 large number of people in the area in which there are teaching  
13 hospitals, who like to get to this teaching hospital. Now if  
PB/RPS 14 you are going to charge for this whether you charge the  
15 individual or whether the insurance company is going to pay for  
16 it, you are setting up a procedure here that I as an individual  
17 living two miles from the Toronto General could walk in and  
18 say I want the service, here is my money. At the same time  
19 I would think you as a teaching hospital would want room to look  
20 after these bizarre cases or the cases that are going to come  
21 from the hinterlands. You have to have room to do this. You  
22 want to do this. In fact, it is your duty. You have to do it,  
23 to look after these cases from out here someplace that have to  
24 be brought in, right?

25 Now, at the present time we have a scarcity of





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1 university teaching hospitals. If you are going to set up  
2 an inpatient and outpatient clinic and some others you say  
3 you can control -- I am wondering if you really can control  
4 these. If you are going to set them up the public will demand  
5 to use them. I throw this out for consideration that if  
6 an employer wants to pay somebody to teach he ought to let  
7 that person teach on the normal supply and demand basis and  
8 leave these hospitals free, not to practice clinical medicine  
9 but to take care of the person that is going to come from  
10 all over the province and not look after all the people that  
11 are on Wellesley Street. We are going to assume all the  
12 people on Wellesley Street now have the money to pay for their  
13 services.

14 DR. LUSSIER: We don't need two people, that  
15 one will teach and one to take care of the sick. You teach  
16 by caring for the patient.

17 DR. BOTTERELL: The problem is we are training  
18 doctors who are going to be doing every kind of practice, to  
19 use the words of Dr. Fraser Dixon. We are really training  
20 the basic doctor, the basic doctor who then goes on and learns  
21 to practice medicine as an interne, general practitioner or  
22 obstetrician or specialist. The teaching hospital has to have  
23 both outpatient practice which resembles the doctor's practice  
24 and on the ward patients which are not related with the problem  
25 case which is also important and also the advancement of medicine



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1 by research and so on. This became clear in the Massachusetts  
2 General Hospital in Boston where they are receiving many, many  
3 complicated cases from all over the world, but they haven't  
4 got the population to draw on to have the common illnesses afflict-  
5 ing mankind. If I may go back, Mr. Chairman, the purpose  
6 of the full-time man is to meet the changing face of medicine.  
7 There has been just as much advance, as we referred to in our  
8 brief in the science of medicine as there has been in mathematics  
9 or science or automation of industry, just as complex, and  
10 progress just as fast. In years gone by a man could conduct  
11 a fair practice, serve the public and at the same time teach  
12 and do research with the tools he was using every day.

13 As our leader, Dr. Warwick pointed out it requires  
14 more man hours to teach the student and all the paramedical  
15 students and the specialists. The teacher must be doing  
16 research. Research is what he is actually doing to patients  
17 as well as laboratory research if he is to be a good teacher.  
18 It follows men will be devoting themselves to a little different  
19 kind of teaching career. In other words you can no longer earn  
20 your living in private practice and teach and do research and  
21 do the administration that goes with the various levels of  
22 the job. So the university -- we must pay out of university  
23 funds the component of that man's total effort that is devoted  
24 to teaching, research and administration.

25 THE CHAIRMAN: Mr. Major, it seems to me the two



by research and so on. This became clear in the Massachusetts  
 complicated cases from all over the world, but they haven't  
 got the population to draw on to have the common illnesses afflict  
 ing mankind. If I may go back, Mr. Chairman, the purpose  
 of the Fellowship was to do some research into the nature  
 of the disease and to see what was going on in the  
 body in the process of cellular changes and how it was  
 or science or automation of industry, just as complex, and  
 progress just as fast. In years gone by a man could conduct  
 a fair practice, serve the public and at the same time teach  
 and do research with the tools he was using every day.  
 As our leader, Dr. Warwick pointed out it requires  
 more man hours to teach the student and all the paramedical  
 students and the specialists. The teacher must be doing  
 research. Research is what he is actually doing to patients  
 as well as laboratory research if he is to be a good teacher.  
 It follows men will be devoting themselves to a little different  
 kind of research. In other words, we can no longer have  
 the same kind of research as we had in the past and the  
 do the administration that goes with the various levels of  
 the job. The administration is a very important part of the  
 funds the component of that man's total effort that is devoted  
 to teaching, research and administration.  
 THE CHAIRMAN: Mr. Mayor, it seems to me the two



1 of you are not on the same wave length. I don't know whether  
2 I am right or I am not. May I make an attempt here to kind  
3 of straighten this out, at least for my own satisfaction,  
4 anyway. I believe that you would prefer to be able to pay  
5 the full-time faculty out of university funds if such were  
6 available?

7 DR. WARWICK: Yes, sir.

8 THE CHAIRMAN: Mr. Major is asking then is  
9 your request for payment through this medical services insurance  
10 as a means through which you might receive that money because  
11 you can't see the money forthcoming from the Government and  
12 other ways to the university to make that payment.

13 MR. MAJOR: That is not what I am looking for,  
14 Mr. Chairman. I am quite happy.

15 THE CHAIRMAN: May I have an answer to that question?

16 MR. MAJOR: I am happy that the university  
17 pay faculty full-time hospital based teachers.

18 What I am interested in is this part-time  
19 teacher that devotes 600, 500, 800 hours a year and gets  
20 \$350 and makes money up out of private practice. The proposition  
21 is that this teacher is now going to be able to charge because  
22 of insurance and this brings about a meet point because  
23 Bill 163 would partly solve the problem but there is a snag.  
24 There is in insurance a clause which says we will not pay for  
25 this if it is only being charged because there is an insurance





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2 of straighten this out, at least for my own satisfaction,  
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Bill 163 it is said before that there is an insurance



1 policy, so you might not get anything out of this if that  
2 clause happens to go into this particular policy. What I  
3 am trying to ascertain, Mr. Chairman, is does the delegation  
4 feel being able to make a charge through clinic set-up they  
5 will recover for a man who is doing 400, 500, 600 hours time  
6 teaching saying I spent 600 and I want \$6,000 and if I spent  
7 800 I want \$8,000 instead of \$350 if there is a modest charge.  
8 If you put it on that basis there is no control as to who  
9 comes in there. The thought that is going through my mind,  
10 if it becomes the order of the day that I can buy my medical  
11 care in that hospital clinic that is where I am liable to buy  
12 my medical care because that is the easiest way for me and  
13 then the hospital becomes the focal point of all medicine.

14                   Who is going to want to go to Sudbury. They  
15 are going to want to stay in Toronto to practice medicine. From  
16 what I have heard we are trying to deploy the doctors through-  
17 out the province. Here we are bringing them in and the patient  
18 will have the right to get in this hospital because he has  
19 paid. How do you keep him away. There is a danger in here  
20 as I see it that because of money we can easily change the  
21 whole pattern of practice to the detriment of the man in private  
22 practice because this man in private practice will become in  
23 direct competition with one of the most powerful forces in the  
24 practice of medicine, the teaching hospital.

25                   DR. ALLEMANG: I would like to say something about



DR. ALLMANG: I would like to say something





1 Mr. Major's fears. I don't think they are really based on the  
2 facts. As things exist at the moment university teaching  
3 hospitals and the staff of these hospitals are in a rather  
4 precarious position for their continued existence. As you  
5 have been told the remuneration of people in university clinical  
6 hospitals is anachronistic, related to the day of Victorian  
7 charity in which one aspired to become on the staff of the  
8 hospitals, acquired a reputation, a large practice, became  
9 a professor and did minimal teaching in addition to this.  
10 The picture has changed completely. There has been marked  
11 progress in medicine caused by general progress in science  
12 since the war. The cost of living has gone up and \$350 goes  
13 a very little way in supporting the clinic teacher.

14 We are looking after a number of different type  
15 patients. We are looking after the needy in the local down-  
16 town areas, as we have from the time there was such hospitals.  
17 We are looking them at the same fee, zero. You get all the  
18 services from the professor within his department free of  
19 charge for these patients. In addition we get plenty of  
20 difficult and varied cases from all over the province. Generally  
21 these ascend in very large numbers to our university service,  
22 public service for which we are also not remunerated. The  
23 income of a bright young chap who comes into the university  
24 clinical medical department and for a number of services he  
25 is paid generally a fellowship, even for the head of a department,



1 and the other part of the work is to do the  
2 work of the hospital and the work of the  
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13 a very little way in supporting one clinic teacher.  
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15 patients. We are looking after the needy in the local down-  
16 town areas, and we are looking after the needy in the  
17 We are looking them at the same fee, zero. You get all the  
18 service that the hospital offers and the hospital pays it.  
19 There is no charge for the service. The hospital is the one  
20 that is looking after the needy and the needy are the ones  
21 that are looking after the needy and the needy are the ones  
22 public service for which we are also not remunerated. The  
23 service is a public service and the service is a public  
24 service and the service is a public service and the service is  
25 a public service and the service is a public service and the service is



1 a few thousand dollars a year. For this he spends a great deal  
2 of time on public service looking after patients for which  
3 no one in his department is remunerated. In addition he  
4 spends a long session on teaching, up to 50 or 75% of his time.  
5 I know this. I have gone through it. The rest of us here have  
6 gone through it. We are not saying we should accumulate any  
7 large funds to pay off people who are practising clinical  
8 university medicine but we are saying you will have no one  
9 left to do this unless you start remunerating these people in  
10 some degree comparable with people working in general practice.  
11 You will have none of them left because if universities don't  
12 pay anything for teaching and you say the insurance scheme  
13 shall continue this Victorian anachronism of charity then we  
14 will get nothing for our patient care. We will be in private  
15 practice. We won't be in university of public service care.

16 In addition people in university medicine try  
17 to practice exemplary medicine. They try to get in the volume  
18 of private practice they reasonable can. We don't try to  
19 get an unlimited practice. You can only look after so many  
20 patients reasonably. My practice is limited. In addition  
21 we are teaching undergraduate students and we are teaching  
22 post-graduate students and we wish to practice ethical medicine.

23 I belong to P.S.I. and my charges are in line  
24 with P.S.I. We don't extra-bill patients. We leave that to  
25 people in the practice of medicine as a career in finance. Experts





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1 I think are relatively few. If one wishes to perpetuate the  
2 medical profession you have to perpetuate a steady stream of  
3 well-trained doctors. That is what the universities are  
4 trying to do and they are receiving very little financial  
5 help for it either in the past or the present. We thought there  
6 might be some hope in the future. It is getting a little  
7 dimmer. All we are asking is this area of service to the  
8 community provided in the university hospital be remunerated  
9 at reasonable rates as they would be if you were in any other  
10 form of practice, which would be remunerated.

11 MR. MAJOR: With all due respect you haven't  
12 convinced me that the method of paying should be what you  
13 suggest. With all thought of the anachronistic system that has  
14 gone on in the past, the Harley Street boys and so on -- all  
15 I am suggesting is that we on this Committee are going to have  
16 to sit down and decide whether it is going to be really cricket  
17 to throw this money problem you have got to insurance or whether  
18 it should be thrown back where it looks like it might be thrown  
19 to the university as an employer on the basis of so many hours.

20 As I see the money problem it is one that is  
21 really a fee-for-service problem, so why it shouldn't be paid  
22 for in this way in an amount that would be reasonably equal  
23 to the fee-for-service and we take the pressure off of seeing  
24 more and more patients.

25 DR. BOTTERELL: It is illegal for a university to



medical profession you have to perpetuate a steady stream of well-trained doctors. That is what the universities are trying to do and they are receiving very little financial help from the government. It is getting a little better. All we are asking is this area of service to the community provided in the university hospital be remunerated at reasonable rates as they would be if you were in any other form of practice, which would be remunerated.

MR. MAJOR: With all due respect you haven't convinced me that the method of paying should be what you suggest. With all thought of the anachronistic system that has gone on in the past, the Harley Street boys and so on -- all I am suggesting is that we on this Committee are going to have to sit down and decide whether it is going to be really cricket to throw this money problem you have got to insurance or whether it should be thrown back where it looks like it might be thrown to the university as an employer on the basis of so many hours. As I see the money problem it is one that is really a fee-for-service problem, so why it shouldn't be paid for in this way in an amount that would be reasonably equal to the fee-for-service and we take the pressure off of seeing more and more patients.

DR. BOTHELL: It is illegal for a university to





1 practice medicine. That is a well-established point in law  
2 that I happened to be investigating recently. It is quite  
3 illegal for a university to look after patients and hire people  
4 to do it. The Sarnia Clinic. . .

5 MR. MAJOR: How do you teach if you don't look  
6 after patients?

7 THE CHAIRMAN: I think we are going to have to  
8 pass these questions to your Chairman and let him field them  
9 rather than for me to act as Chairman for your delegation. Dean  
10 Warwick, would you take the questions and delegate them  
11 to the ones in your delegation who you would like to answer  
12 them. Otherwise I am going to act as Chairman for your group  
13 too.

14 DR. WARWICK: I am not sure there is a question  
15 before us at the present time.

16 MR. MAJOR: Can we leave this particular subject  
17 and go to page 14 which has already been mentioned, \$193,000  
18 for laboratory and X-ray services.

19 I wonder, Dr. Warwick, if it would be reasonable  
20 to suggest that these services don't necessarily include, these  
21 costs, they do not include the services of a physician.

22 DR. WARWICK: I think Dr. Allemang could answer  
23 this better than myself because it had to do with an outpatient  
24 hospital in the Toronto area.

25 DR. ALLEMANG: I am not sure I can answer this





1 because these are figures drawn from one of the hospitals and  
2 I haven't got the detail of it at hand. There are no charges  
3 in outpatients for physician services so I would be left to  
4 draw the conclusion these apply to nursing personnel, social  
5 services et cetera.

6 MR. MAJOR: Wouldn't this be a proper place  
7 to have this included in the Ontario Hospital Services? Might  
8 I ask the question this way and you may not know the answer,  
9 but, with all deference, you may. Who picks up the deficit  
10 if there is a true deficit, who pays for it?

11 DR. ALLEMANG: That is in the gross hospital  
12 account, the Ontario Hospital Commission.

13 MR. MAJOR: Why don't they pick it up, collect  
14 it from the Ontario Service Commission?

15 DR. ALLEMANG: The Commission presumably isn't  
16 paying for it.

17 MR. MAJOR: It isn't a professional matter, it  
18 is a question of whether the Commission will accept the  
19 liability.

20 DR. ALLEMANG: Yes.

21 MR. MAJOR: Thank you.

22 DR. ALLEMANG: May I say something further here.  
23 When we are talking about all these costs of laboratory and  
24 X-ray services and other costs there are comparable costs in  
25 hospitals that are covered by the Ontario Hospital Services Commis-



services of others.

MR. MAJOR: Wouldn't this be a proper place

for that kind of thing? Medical services, right?

I am not saying that that is the only way to do it.

But, with all deference, you may. Who picks up the deficit

if there is a true deficit, who pays for it?

DR. ALLEMAN: That is in the gross hospital

account, the Ontario Hospital Commission.

MR. MAJOR: Why don't they pick it up, collect

it from the various medical commissions?

DR. ALLEMAN: The Commission presumably isn't

paying for it.

MR. MAJOR: It isn't a professional matter, is

it a question of medical administration with regard to

hospitality?

DR. ALLEMAN: Yes.

MR. MAJOR: Thank you.

DR. ALLEMAN: May I say something further here.

There are two things that are being done at present, and

they are being done in a very hasty manner, and the

result is that the medical profession is being



1 sion. Some of them recently have been competent that outpatient  
2 services might reasonably at some time be covered by the  
3 same agency. At the same time if we look over the Bill for  
4 medical services we realize there is a profession component  
5 involved in laboratory services as well as the cost of providing  
6 these services through the mechanics and the raw materials that  
7 go into them. It is not very much use having an elaborate  
PE/RPS 8 X-ray system unless you have a doctor trained to interpret  
9 and give a report on it. So there are professional components  
10 involved, as well.

11 MR. MAJOR: Dr. Warwick, there is one set of  
12 wording here in another brief and I would like your comment,  
13 or the comment of you gentlemen, whom I look upon as being  
14 the ultra-experts in this type of work, and it says:

15 "Instruction and guidance in the basic  
16 "principles of personal hygiene should form  
17 "an increasing part of the work of the individual  
18 "physician, whether at his office, the patient's  
19 "home or in the hospital."

20 Now, the delegation presenting this would lead  
21 you to believe that this was not now being done. Is this so?

22 DR. WARWICK: Is the phrasing "personal hygiene"?

23 MR. MAJOR: Yes.

24 DR. WARWICK: The teaching of personal hygiene?

25 MR. MAJOR: "Instruction and guidance in the basic



services might reasonably at some time be covered by the same agency. At the same time if we look over the Bill for medical services we realize there is a professional component involved in the delivery of the service. It is not very much use having an elaborate X-ray system unless you have a doctor trained to interpret and give a report on it. So there are professional components involved, as well.

MR. MAYOR: Dr. Wawrock, there is one set of wording here in another title and I would like your comment, or the comment of your gentleman, whom I look upon as being the ultra-experts in this type of work, and it says:

"Principles of personal hygiene should form an increasing part of the work of the individual physician, whether at his office, the patient's home or in the hospital."

Now, the delegation presenting this would like you to believe that this was not now being done. Is this so?

DR. WAWROCK: Is the phrasing "personal hygiene?"

MR. MAYOR: Yes.





1 principles of personal hygiene should form an increasing part  
2 of the work of the individual physician, whether at his office,  
3 the patient's home or in the hospital."

4 DR. WARWICK: I am not quite sure what is meant,  
5 but I think personal hygiene is something that starts in the  
6 family and through the person's lifetime. Certainly, our  
7 students of medicine are taught preventive medicine in this  
8 field.

9 MR. MAJOR: That is what I would assume, and I  
10 do not know of any doctor that has ever gone to my home or  
11 anybody's home that hasn't told them "You should not be doing  
12 this or that" or "You should be doing something else". I wanted  
13 this statement clarified on the record.

14 THE CHAIRMAN: Are you finished your questioning,  
15 Mr. Major?

16 MR. MAJOR: Yes, thank you.

17 THE CHAIRMAN: Mr. Naylor?

18 MR. NAYLOR: I will not take very long. Among  
19 your four recommendations, the second one seems to be the one  
20 that falls within our terms of reference most, I believe, that  
21 payments be paid for services rendered in a clinic. Do you  
22 consider that any change in the Bill would be needed to accomplish  
23 this? It appeared to me that as the Bill stands now, it would  
24 do this.

25 DR. WARWICK: Mr. Chairman, I think I am correct



1 of the work of the individual physician, whether at his office,  
2 the patient's home or in the hospital."

3 DR. WARREN: I am not quite sure what is meant,

4 family and through the personal life-time. Generally, our  
5 students of medicine are taught preventive medicine in this

6 MR. MAJOR: That is what I would expect, and I

7 this statement clarified on the record.

8 THE CHAIRMAN: And you finished your statement.

9 MR. MAJOR: Yes, thank you.

10 THE CHAIRMAN: All right.

11 MR. MAJOR: I will not take any more time.

12 Your four recommendations, the second one seems to be the one  
13 that falls within our realm of reference most, I believe, that

14 I believe to have the greatest impact on the public health.

15 I believe that the first recommendation is the one that is most

16 important to the public health, and I believe that it is the one

17 that is most important to the public health, and I believe that it is the one

18 that is most important to the public health, and I believe that it is the one



1 in saying that nowhere in the Bill does the word "teaching"  
2 appear and nowhere in the legislation does the word "teaching  
3 hospital" -- nowhere in the Ontario Hospitals' Act, the  
4 O.H.S.C. or anywhere else, does the word appear, and our feeling  
5 is -- and I think I speak for my colleagues -- that somewhere  
6 in this Act, teaching units or teaching hospitals must be  
7 recognized. Now, whether that should be an amendment to the  
8 Public Hospitals' Act and then referred to here, I do not  
9 know. But it is not covered at the present time.

10 THE CHAIRMAN: May I comment on that? It  
11 starts off by saying:

12 "Professional services of a physician,  
13 "wherever rendered . . ."

14 DR. WARWICK: "Professional services . . ." --  
15 I see what you mean. In other words, if it is given in a  
16 teaching unit, then it would be . . .

17 THE CHAIRMAN: Unless it is excluded -- ". . .  
18 wherever rendered" would be my interpretation as all-inclusive,  
19 with the exception of those things that are listed.

20 DR. ALLEMANG: If I may make a supplemental  
21 reply to Mr. Naylor. In trying to anticipate these problems  
22 and deal with them within the scope of a large hospital, such  
23 as the one I am at, one forgets the possibility in which you  
24 may have to recover funds from these sources. It would seem  
25 to us, and someone has to start leading the view on this in





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wherever rendered" would be my interpretation as all-inclusive,

with the exception of those things that are listed.

DR. ALLENBANK: If I may make a supplementary

reply to Mr. Naylor. In trying to anticipate these problems

and deal with them within the scope of a large hospital, such

as the one I am at, one "forgets" the possibility in which you

may have to recover funds from these sources. It would seem

to us, and someone has to start leading the view on this in



1 respect to all university teaching hospitals-- we have advanced  
2 to the stage that we feel we should form a medical staff  
3 association of people with university appointments, that  
4 this body should be a collective agency for monies that might  
5 accrue to it under any future legislation in the area of  
6 patient care of patients in clinical teaching units, and that  
7 it should be disbursed in conjunction with and in agreement  
8 with all the doctors, the hospital staff, providing the service  
9 and in agreement with the university. The difficulties of  
10 setting up such a body appear to be rather real and, since this  
11 will affect every university hospital within Ontario, it would  
12 seem to us in the staff association of our own hospital that  
13 it might be facilitated if such an organization were recognized  
14 as a body that might reasonably represent the doctors in a  
15 university hospital in dealing with this problem. It will  
16 affect all university hospitals and it might affect other non-  
17 university hospitals to some extent, as well. But I am sure  
18 it would facilitate dealing with this particular problem if  
19 some thought and recognition were given to this agency before  
20 the Bill were written in a final form.

21 DR. WARWICK: Might I just say that I think one  
22 of the reasons why that was put in was because at the present  
23 time, I mean, doctors give services of such units for clinical  
24 staff, or what-have-you, and receive no remuneration.

25 MR. NAYLOR: They would if the patient receiving



1 request to all university teaching hospitals-- we have advanced  
2 to the idea that we feel we should form a medical staff  
3 association of people with an interest in the hospital, and  
4 this body should be a collective agency for monies that might  
5 accrue to it under any future legislation in the area of  
6 patient care of patients in clinical teaching units, and that  
7 it should be disbursed in conjunction with and in agreement  
8 with all the doctors, the hospital staff, providing the service  
9 and in agreement with the university. The distribution of  
10 funds would be made by the hospital staff, and the university  
11 would be responsible for the distribution of the funds.  
12 It seems to me in the staff association of our own hospital that  
13 it might be facilitated if such a organization were recognized  
14 as a body that might represent the doctors in a  
15 university hospital in dealing with these problems. It will  
16 affect all university hospitals and it might affect other non-  
17 university hospitals to some extent, as well. But I am sure  
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19 some thought and recognition were given to this agency before  
20 the bill were written in a final form.

DR. WADSWORTH: About I just say that I think the  
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1 the service were insured with a commercial company. Most  
2 companies would pay, wouldn't they?

3 DR. WARWICK: Yes. But, there is a difference  
4 in different hospitals. In some cases the money does not go  
5 directly to the doctor concerned, it goes into a fund for  
6 use for educational purposes.

7 MR. WHITNEY: Do you mean the professional  
8 fee is collected and it is put into a fund and used in other  
9 ways?

10 DR. WARWICK: Yes.

11 MR. WHITNEY: Is that professional?

12 DR. WARWICK: Is it what?

13 MR. WHITNEY: Is it professional? Is that  
14 professional, taking fees and using them like that?

15 DR. WARWICK: I think that if a service is  
16 rendered and if the doctors rendering the service, if they  
17 are entitled to charge fees, then it is their privilege to do  
18 with the fees what they wish.

19 MR. WHITNEY: I suppose that is by consent?

20 DR. WARWICK: Yes.

21 MR. WHITNEY: They are making a donation of  
22 what they are personally entitled to?

23 DR. WARWICK: But it is done in agreement with  
24 the doctors.

25 MR. WHITNEY: There is something wrong with the



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23 what they are personally entitled to?  
24 DR. WARWICK: But it is done in agreement with  
25  
26 MR. WHITNEY: There is something wrong with the



1 agreement, then.

2 MR. SIMON: I think they need a union.

3 MR. WHITNEY: Under the Ontario Welfare Plan  
4 do you have an income coming in from that for the welfare  
5 patients that you do take care of in teaching hospitals?

6 DR. WARWICK: There is nothing from the stand-  
7 point of professional fees.

8 DR. HAMILTON: Are professional fees collected  
9 from welfare patients when they come to a hospital as an out-  
10 patient?

11 DR. WARWICK: I think one of my colleagues can  
2 12 answer this. All I can say is that I have looked after many  
13 welfare patients and I haven't ever received a cent.

14 DR. HAMILTON: The answer is no? Nor is a fee  
15 paid when they are inpatients?

16 DR. ALLEMANG: No.

17 MR. WHITNEY: I have an off the record observation.

18  
19 ---Off the record discussion.  
20

21 THE CHAIRMAN: Are there further questions from  
22 any of the members of the Enquiry?

23 MISS McARTHUR: I have one small question. On  
24 page 15, the second principle where you indicate that outpatient  
25 departments of teaching hospitals should accept no more patients





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answer this. All I can say is that I have looked after many

welfare patients and I haven't ever received a cent.

DR. HAMILTON: How much do you get for a day

paid when they are inpatients?

DR. ALTMAN: No.

MR. WHITNEY: I have an old record book which

---off the record discussion.

THE CHAIRMAN: Are there further questions?

any of the members of the Society?

MR. WHITNEY: I have one small question. On

page 15, the second principle where you indicate that outpatient

departments of teaching hospitals should accept no more patients



1 than is necessary. In other words, you feel that if it is  
2 a teaching hospital, the teaching group should control the  
3 number of patients that are being handled in the outpatient  
4 department?

5 DR. WARWICK: If I may attempt to answer that.  
6 If the hospital is to be truly a teaching hospital, it really  
7 needs a sufficient number of patients to perform its functions,  
8 to do investigative work and train other personnel. If the  
9 service component becomes too large, the aims and the functions  
10 of what the folks are trying to do in teaching hospitals fall  
11 down because they are swamped with the service load. They are  
12 not anxious to have too much of a service load.

13 MISS McARTHUR: It sounds familiar, sir.

14 THE CHAIRMAN: Dr. Butt?

15 DR. BUTT: This question is really related to  
16 something Mr. Major said -- that the teaching hospital, that  
17 you have mentioned, Dr. Warwick, was not mentioned in the  
18 Bill. When you mentioned a teaching hospital, I think you are  
19 really a department of the university. I think this is the  
20 component we are talking about. And I think the same thing  
21 happens to research, that as you increase the clinical or the  
22 service load, then you will have less teaching; so you are,  
23 in essence, in some way defeating your own purpose. Is this  
24 correct? I admit that there is a teaching component in giving  
25 service, but your geographical full-time teacher that you mentioned



than is necessary. In other words, you feel that it is in a teaching hospital, the teaching group should control the number of patients that are being handled in the outpatient

DR. WARWICK: If I may attempt to answer that.

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MISS MCARTHUR: Is anyone familiar, sir.

THE CHAIRMAN: Yes, please.

DR. BORT: This question is really related to something Mr. Major said -- that the teaching hospital, that you have mentioned, Dr. Warwick, was not mentioned in the Bill. When you mentioned a teaching hospital, I think you are really a department of the university. I think this is the component we are talking about. And I think the same thing happens to research, that as you increase the clinical or the service load, then you will have less teaching; so you are, in essence, in some way defeating your own purpose. Is this correct? I admit that there is a teaching component in giving





1 is necessary for teaching and not for service; is that correct?

2 DR. BOTTERELL: I am not quite sure of your  
3 question.

4 DR. BUTT: If you want more teaching and you  
5 want more research, then this should be and you should look for  
6 your hard core funds, using your words, from a university  
7 department and so go after it, rather than ask for more service  
8 which, in essence, if you are going to give more service, you  
9 have to give more time and, therefore, you are defeating your  
10 purpose. This is what I am trying to say.

11 DR. BOTTERELL: This is correct. This is why  
12 the universities need substantially larger budgets to pay men  
13 who are devoting two-thirds to 80% of their time to teaching,  
14 service and administration. They pay them as geographical  
15 full-time and part-time people because they give a large percent-  
16 age of their time to this.

17 So, it is necessary to establish a middle course  
18 where there are enough patients for purposes of educating  
19 doctors and all the others and for purposes of special problems,  
20 and not swamping your staff with service.

21 DR. BUTT: I agree. But the first point is  
22 that if you want to increase the teaching, you must get hard  
23 core funds and not mix it with the service?

24 DR. BOTTERELL: That is correct.

25 DR. BUTT: And in 13 and 14, where you give your



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question.

DR. BUTT: If you want more teaching and you

want more research, then this should be and you should look for

your hard core funds, using your words, from a university

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DR. BUTT: And in 13 and 14, where you give your



1 breakdown of outpatients, one of the factors in service, render-  
2 ing in service of a doctor, and one of the things he is paid  
3 for is that he has overhead as well and I think it costs them,  
4 very roughly, in the neighbourhood of 40%?

5 DR. BOTTERELL: Yes.

6 DR. BUTT: So the facilities, at the 40% figure,  
7 would be supplied by the hospital. Then you are working in  
8 theoretical competition in a neighbourhood area at a 40% advant-  
9 age over anybody in the area. Whether you say no, this actually  
10 would be a fact. The other thing that goes into this is the  
11 training of the basic doctor. You said it should resemble  
12 a doctor's office and he has a cross-section of the population.  
13 What is the possibility of saying: All right, we will collect  
14 this fee. If we are going to collect it out of insurance and  
15 this part, the outpatient part may be used or spread in some  
16 way, and then you were running a private practice in the true  
17 sense of the word and even making home calls, or some of your  
18 people are going to do it, this would be certainly within the  
19 terms of the bill for rendering service and it is not confused  
20 on that particular aspect with actual teaching. Your teaching  
21 would come in at that level. But if you move it into the  
22 hospital, then you are in a 40% differentiation and then your  
23 whole economics is changed.

24 DR. BOTTERELL: On page 10, under the heading  
25 "V", sub-paragraph (III), I think the answer is there to Dr. Butt's





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1 question.

2 DR. WARWICK: It states there, Dr. Butt " . . .  
3 may enter into arrangements whereby the hospitals may be  
4 reimbursed for a reasonable portion of these."

5 DR. BUTT: Why wouldn't you move it? If you  
6 want to have a service and not confuse it with the actual  
7 hard core of teaching . . .

8 DR. CHALKE: Mr. Chairman, the teaching has  
9 to take place where the patients are. You can't say there  
10 are teachers over here spending X part of their time and the  
11 other half of their time they are rendering a clinic service.  
12 There is a suggestion in the statement that the less patients,  
13 the better the teaching is going to be. Well, the clinical  
14 teaching service that has been recommended is 10 beds per  
15 graduate student. It would work out to somewhere around 3,000  
16 teaching beds. And just talking about inpatient, the clinical  
17 service rendered to 3,000 inpatients is a big chunk because  
18 we have 30,000 hospital beds in Ontario. So, 20% of that would  
19 be rendered by universities, by the teaching staff. I do not  
20 think we can expect the universities to pay for it and, yet,  
21 we have to render that much clinical service, plus the outpatient.  
22 I do not see any objection that it could be across the street,  
23 but the students would have to be across the street too.

24 DR. BUTT: Yes. If you are going to receive money  
25 for servicing those patients, then you should, in the same time,



question.

DR. WARRICK: It states there, Dr. Butt " . . .

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DR. BUTT: Yes. If you are going to receive money

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1 accept the cost or the overhead. This is what I am saying.  
2 Your in-patient, I have no question about that -- there should  
3 be a certain amount in there.

4 DR. LUSSIER: We mentioned that the overhead  
5 should be paid by the physician to the hospital.

6 DR. BUTT: To the hospital?

7 DR. LUSSIER: For the overhead of the out-  
8 patient department that they are using.

9 DR. BUTT: I read that.

10 DR. LUSSIER: That is what we referred to. And  
11 other problem of operating an out-patient clinic across the  
12 street or a block away is that the medical student is not to  
13 be assigned 24 hours a day to the out-patient department.

14 DR. BUTT: No. I agree. However, he could  
3 15 move out and there is still the home call and the resident  
16 service factor which you are including in one figure and  
17 not in the other.

18 DR. WARWICK: I think the Committee should know  
19 that at my own university we may have as officers of  
20 instruction -- it is getting close to the 250 figure. For  
21 the clinical science, there would be 150 or 125 part-time  
22 teachers and possibly 20 or 30 geographical full-time teachers.  
23 I am wondering whether that distribution helps you in your  
24 consideration. We have no intention at the present time of  
25 making all of our teachers geographical full-time teachers.



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consideration. We have no intention at the present time of  
making all of our teachers geographical full-time teachers.



1 THE CHAIRMAN: What are those figures again?

2 20 to 30 geographical full-time?

3 DR. WARWICK: Clinical teachers.

4 THE CHAIRMAN: And how many part-time teachers?

5 DR. WARWICK: 125. We are including general  
6 practitioners in our out-patient departments. We want the  
7 student to be exposed to the general practice under the most  
8 ideal circumstances possible, so students can see the whole  
9 thing in operation right there. And we regard part-time  
10 teachers as equally as valuable as geographical full-time  
11 teachers -- at Queen's.

12 MR. CASWELL: It would appear to me that in  
13 Bill 163 there would be no difficulty in covering the  
14 patients whether they are in the university hospital or else-  
15 where, but where there might be some complication and perhaps  
16 where the faculties can give us some help, is how this would  
17 be administered because certainly it is not the plan at the  
18 present plan, I do not think, to pay this money into one  
19 central source and that is what the doctors are suggesting,  
20 that if it was paid into one central source, they could distrib-  
21 ute it on an agreement between themselves and the hospital.

/MR/RPS 22

23 I would think it would be of help to us to  
24 have a statement from the faculty in a little more detail as  
25 to what their proposal would be; as to how the monies would  
be handled, how the distribution would be handled. Certainly we





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have a statement from the faculty in a little more detail as

to what their proposal would be; as to how the money would



1 would have to make some recommendation that would include this.

2 MR. MAJOR: One question. One of you gentle-  
3 men said universities cannot practise medicine. Can hospitals  
4 practise medicine?

5 DR. WARWICK: I think the answer is no sir.

6 MR. MAJOR: Thank you.

7 DR. GALLOWAY: May I have one moment just to  
8 clarify something? Earlier on I brought out the point there  
9 are 700,000 visits by people as out-patients to the teaching  
10 hospital and you have brought out the point that you at the  
11 present time receive money from insured people, and I think  
12 it should be clear, because you have left us with some  
13 impression, that there is no money at the moment being collected  
14 from insuring companies; that the percentage of people on your  
15 public wards must be close to the actual average or percentage  
16 of people who are insured throughout the population. At the  
17 moment we take it 65 to 70%, maybe it drops down as low as 50%.  
18 Could you give us some idea on that figure and if so, it may  
19 well indicate that the actual cost to the insuring companies  
20 is going to be very much less than you have given us the  
21 impression of.

22 DR. WARWICK: Mr. Chairman, I don't know the  
23 figure but maybe Dr. Kinch can help us.

24 DR. KINCH: I think that as our out-patients are  
25 run, at present where we have very small out-patient material,



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23 figure but maybe Dr. Kinch can help us.

24 DR. KINCH: I think that as our out-patients are

25 run, at present where we have very small out-patient material,





1 and this is the point you perhaps would like to clarify.  
2 Dr. Galloway, at the beginning of this discussion, suggested  
3 that we would not expect a falling-off of out-patient material  
4 because of the fact that the welfare patients would still be  
5 there and our feeling is one of the purposes of this Bill is  
6 to eliminate the so-called second-class citizen. Maybe he  
7 will remain in spirit, but in fact he should be eliminated and  
8 there will be no differential in payment to the doctor for  
9 any welfare patient or any other kind of patient and this may  
10 well result in us losing a fair proportion of our welfare  
11 patients.

12 Mr. Major on the same basis said he would go  
13 to the out-patient clinic for his treatment because it was  
14 convenient. I have many patients who are not happy really to  
15 go to the out-patient clinic because they know that they are  
16 going to be seen by students, and especially my own field,  
17 gynaecology, it is hard to expect women to be examined by  
18 students in the out-patient department. I think this is another  
19 problem we have.

20 In trying to answer Dr. Warwick's question, I  
21 would think probably about somewhere between 10 or 15% of our  
22 gynaecologic out-patients are people who are insured either  
23 when they go into hospital and they don't know they are insured,  
24 or else somehow or other get the knowledge when going to a  
25 private doctor. I think the percentage is a little higher in



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 gynecologic out-patients are people who are insured either  
 when they go into hospital and they don't know they are insured  
 private doctor. I think the percentage is a little higher in



1 surgery and a little lower in medicine.

2 If you take the 15% run, you would get about the  
3 right number in our institution that are covered with third  
4 party, what we call third party insurance.

5 MR. NAYLOR: Actually under the service plan  
6 I presume they do not pay for this service?

7 DR. KINCH: Yes, they do.

8 MR. NAYLOR: What is the percentage of in-patients  
9 particularly though? They are your out-patients?

10 DR. KINCH: As far as I know they are never  
11 charged. Only in-patients find out they have the insurance.

12 DR. WARWICK: I believe Dr. Allemang can say  
13 something on this.

14 DR. ALLEMANG: I can give you a variation within  
15 our own department, obstetrics and gynaecology of the Toronto  
16 General Hospital. Over the past five or six years our third  
17 party funds, our collections have varied between two and ten  
18 per cent of the service performed.

19 THE CHAIRMAN: Ladies and gentlemen, I would  
20 suggest that while there may be further questions we would like  
21 to ask, we can find those out ---

22 MR. MAJOR: Just one more question. Do the  
23 insurance companies pay your bill?

24 DR. KINCH: Yes.

25 THE CHAIRMAN: Is there any further statement that



1 surgery and a little lower in medicine.

2 If you take the 1934 run, you would get about the

3 party, what we call third party insurance.

4 MR. MAYNOR: Actually under the new law, isn't

5 I presume they do not pay for this service?

6 DR. KINCH: Yes, they do.

7 MR. MAYNOR: What is the percentage of in-patients

8 particularly through? They are your out-patients?

9 DR. KINCH: As far as I know they are never

10 charged. Only in-patients find out they have the insurance.

11 DR. WAINWRIGHT: I believe Dr. Allingham can say

12 DR. ALLINGHAM: I can give you a variation within

13 our own department, obstetrics and gynecology of the Toronto

14 General Hospital. Over the past five or six years our third

15 party funds, our collections have varied between two and ten

16 per cent of the service performed.

17 THE CHAIRMAN: Ladies and gentlemen, I would

18 to ask, we can find those out ---

19 insurance companies pay your bill?

20 THE CHAIRMAN: Is there any further statement?



1 you would wish to make on behalf of your delegation?

2 DR. WARWICK: No, I don't think so sir. I  
3 would like to ask Dr. Vandewater if he wishes to say something.

4 DR. VANDEWATER: Mr. Chairman, I would just  
5 like to say one last thing and that is something that Mr. Major  
6 brought up, because he left us in a squirrel cage and to look  
7 back, I think he left us hanging in the air a little bit on the  
8 matter of competition. I would hate to go away and leave it  
9 the way he said it. He suggested that with our submission this  
10 would establish, if this came into being, teaching hospitals  
11 in competition with practitioners at large. This is true, and  
12 we recognized this and we did recognize it in our earlier  
13 deliberations and said so in presentations elsewhere but we  
14 feel that this is necessary because it may be true that here  
15 in the City of Toronto out-patient clinics would discontinue or  
16 would not continue but perhaps they would continue to be  
17 well-attended by people who are unable to pay or who have  
18 insurance and that likely go anywhere anyway, but I feel that  
19 in teaching hospitals, perhaps in other areas, that they have  
20 felt already the brunt of health insurance and that generally  
21 speaking their clinics are falling off in attendance and the  
22 out-patient clinics are not wholly in a position within the  
23 university as far as teaching is concerned that they should  
24 be and that they have been in the past.

25 We feel that this is a healthy competition and



1 The first thing I want to mention is that I don't think so sir. I  
2 DR. WARWICK: No, I don't think so sir. I  
3 would like to see the evidence of the evidence of the evidence  
4 DR. VANDEWATER: Mr. Chairman, I would just  
5 like to say one last thing and that is something that Mr. Major  
6 mentioned, because he said that a separate act and so on  
7 and I think that is the case in the Act. I think that is the  
8 matter of competition. I would hate to go away and leave it  
9 for the record, but I think that is the case in the Act. I think  
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19 in some of the hospitals in the city, I think that is the case  
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25 We feel that this is a healthy competition and





1 that people who have insurance have a choice of going to a  
2 doctor's office, and if they live in an area where there is  
3 a teaching hospital, they also have the choice of going to the  
4 teaching hospital and then you said yourself, but I question  
5 very much sir whether you actually would attend an out-patient  
6 clinic but you have the choice now. One moment please.  
7 Nevertheless, I feel that you overemphasized the competition  
8 aspect and that this would put us at an advantage, and I do  
9 not believe this, and I am quite sure that the members of  
10 our Committee do not believe this either, although we feel  
11 that if we are going to provide an attractive out-patient  
12 service, we are going to have to work hard to provide a service  
13 that is anything as good as the practitioner now provides  
14 in the private office, and the patients get. We feel that  
15 we can do this but it is going to take time, take a considerable  
16 increase in our out-patient staff and they are understaffed  
17 now, for the simple reason you cannot get a doctor to spend  
18 time there. Why should he? They are too busy attending to  
19 their own practice in their own office.

20 Secondly, we feel, and we have so stated, that  
21 the out-patient clinics are primarily for attending the sick,  
22 the people who need attention would, consequently, provide  
23 teaching material and it has been well pointed out, I believe  
24 there is a limit to this and we fully intend to stick within  
25 this limit. We have to, if the out-patient clinics are to be



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2 doctor's office, and if they live in an area where there is  
3 a teaching hospital, they also have the choice of going to the  
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19 their own practice in their own office.

20 Secondly, we feel, and we have so stated, that  
21 the out-patient clinics are primarily for attending the



1 a teaching service.

2 DR. WARWICK: I might just finish off sir  
3 by saying we agree wholeheartedly with what Dr. Vandewater  
4 said. If we are going to succeed in attracting people to  
5 our out-patient clinics, and maintain the teaching material  
6 which we need, we would hope it would be by reason of the  
7 excellence of the care given rather than for any economic  
8 reasons.

9 MR. MAJOR: I agree sir. That is why I come  
10 back to the other point, it just doesn't make any difference  
11 where the money comes from if you can get the help to pay for  
12 it.

13 THE CHAIRMAN: Gentlemen it has been a very  
14 interesting session. I appreciate your patience and I am  
15 hopeful that it will prove fruitful.

16 DR. WARWICK: Thank you.

17  
18  
19  
20  
21  
22  
23  
24  
25





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DR. WARWICK: Thank you.



SUBMISSION OF REVEREND H.L. WIPPRECHT,  
CHAIRMAN OF TEMISKAMING PRESBYTERY, THE  
UNITED CHURCH OF CANADA, COBALT, ONTARIO

Appearance: Rev. H.L. Wipprecht

THE CHAIRMAN: You have had an opportunity of reading the statement of instructions have you?

REV. WIPPRECHT: Yes, I have just got it here.

THE CHAIRMAN: Do you wish to proceed sir?

REV. WIPPRECHT: By way of summation of the main points, the overall principle of my presentation is to the effect that health care and health is indivisible. I do not see why one should make a difference between standard care, drugs, or general health care furnished by doctors and, therefore, I think if the plan, the legislation is to be made much more comprehensive, it should include drugs as obviously there is no point in going to a doctor and getting a prescription and then not having the money to buy the drugs. It should include dental work. Now we know for a fact, this is something that the medical world knows, any layman knows, but apparently the people who drew up the draft legislation did not seem to be aware of this, that tooth decay may lead to many other serious diseases such as rheumatic disease, strep infections, disease of the kidneys and heart, so, therefore, why is the dental care out?

Furthermore, the same thing could be said about

CHAIRMAN OF THE BOARD OF HEALTH, THE

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is something that the medical world knows, any layman knows,

but apparently the people who drew up the draft legislation

did not seem to be aware of this, that tooth decay may lead to

many other serious diseases such as rheumatic diseases, kidney

infections, disease of the kidneys and heart, so, therefore,

why is the dental care out?

Furthermore, the same thing could be said about





2 1 the care of the eye. The eye is one of the body's most  
3 precious, most sensitive organs. Why should it be treated as  
4 a second-class member of the body? Eyeglasses, for instance,  
5 why should they not be included, the purchase of eyeglasses?  
6 I could have included, I forgot it at the time, but I will just  
7 mention it, artificial limbs too, artificial glasses. In  
8 other words, everything. I do not see why one makes a  
9 division between different types of health care.

10 The second major point is the financing of the  
11 plan which to me is not quite fair. In fact, I would go as  
12 far as to say it is not within reach of quite a few of our  
13 citizens who are in the lower, or even middle income bracket.  
14 I will very briefly elaborate, and I say briefly, on these  
15 various points.

16 Take the matter of drugs, for instance. Now  
17 if in my own livingroom somebody drops a hot ash on my suit  
18 and burns a hole in it and I need a new suit quickly, I can  
19 get it by way of insurance. I have fire insurance which covers  
20 such emergencies; have to buy me a new suit but if my wife,  
21 which she did, being pregnant, has to get a quick shot of  
22 gammaglobulin because there are German measles going around,  
23 that is not covered. I cannot get insurance for that. I have  
24 to quickly search for \$40 and fortunately I happened to have  
25 it but it was just a coincidence. If it had been a day or  
a week before my payday, I might not have had it. Not being



the care of the eye. The eye is one of the body's most  
precious, most sensitive organs. Why should it be treated as  
a second-class member of the body? Examinations, for instance,  
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to quickly search for \$40 and fortunately I happened to have  
it but it was just a coincidence. If it had been a day or  
a week before my payday, I might not have had it. Not being



1 an indigent, I was not qualified for free care. I had to have  
2 the money or else my wife would have had to go without these  
3 most important shots, two for \$40-some dollars because as you  
4 may or may not know German measles to a pregnant woman -- they  
5 are not so much dangerous to the woman as to the foetus  
6 which might be deformed.

7 In other words, drugs to me are just as  
8 important as anything else, or more so. Now in the second  
9 place, we do have voluntary insurance plan I understand operat-  
10 ing in certain parts of the Province. I checked this out with  
11 one of our druggists up north in New Liskeard. He used such  
12 words as confusion and uncertainty and they do not have any-  
13 thing up north. We cannot insure ourselves through private  
14 means. Now I leave it up to your discretion to pass your own  
15 judgment on the general picture concerning what the private  
16 agencies do in this field. If there is confusion, if nothing  
17 is done, if part of the Province has it and the other does  
18 not have it, to me it proves one thing: that the Government  
19 should step in and do something about it. Otherwise nobody  
20 will.

21 Now as far as dental care is concerned, again  
22 this is a most serious situation. I discussed it with several  
23 teachers and school principals and again there is a hodge-podge,  
24 a patchwork of means being taken. For instance, in Terrace  
25 which is about 35 miles away from the nearest dentist, all the





an indigent, I was not qualified for free care. I had to have the money or else my wife would have had to go without these most important shots, two or three dollars because as you may or may not know German measles to a pregnant woman -- they are not so much dangerous to the woman as to the foetus

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important as anything else, or more so. Now in the second place, we do have voluntary insurance plan I understand operating in certain parts of the Province. I checked this one with one of our druggists up north in New Liskeard. He said that words as confusion and uncertainty and they do not have anything up north. We cannot insure ourselves through private means. Now I leave it up to your discretion to have your own agencies do in this field. If there is confusion, it is nothing is done, all part of the Province has it and the other does not have it, to me it proves one thing: that the Government should step in and do something about it. Otherwise nobody

Now as far as dental care is concerned, again this is a most serious situation. I discussed it with the teachers and school principals and again there is a patchwork of means being taken. For instance, in New Liskeard which is about 35 miles away from the nearest dentist, all the



1 children get free dental care. Free dental care. We are  
2 not so fortunate in Cobalt. We live five miles away from the  
3 nearest dentist and either we go to him and pay for what we  
4 get, or else we don't get it. Now again, and mind you we  
5 do not have enough dentists and many parents perhaps could not  
6 care less. That may be some of the trouble, but in the third  
7 place and last, but not least, there are those urgent cases  
8 where children have toothaches and where the family just  
9 cannot afford to send them to the dentist which I know for  
10 a fact because I was told so by several people, and some of  
11 them are not exactly paupers. If they have many children,  
12 and they have to pay \$4 or \$5 for a tooth to be filled or  
13 for various types of work to be done, and some of these child-  
14 ren have many teeth to be looked after, and this is a most  
15 deplorable condition, the family just cannot afford it, and  
16 the same argument -- I won't take up any more time -- could  
17 be applied to optometrists. I do not see why -- the words  
18 "Victorian charity" were used here. I do not see why in this  
19 day and age, in a country that has the second or third highest  
20 standard of living in the world, why one should have to go  
21 cap-in-hand to the Kiwanis or the Lion's and beg for a set  
22 of eyeglasses. That is the way these so-called indigents, or  
23 the indigents, not just so-called, get their eyeglasses.  
24 Now this ought to be put on a more equitable and  
25 less humiliating basis.



children get their dental care, these dental care, we are  
not so fortunate in Canada. We give this money away from the  
nearest dentist, and they are not paid, they are not paid,  
and, on this we don't get it. The money, and what you do  
it, we have a small dentists and many dentists, and we are  
very poor. That is the case of the dentists, but in the same  
place and time, but not least, there are many dentists, and  
we are children, and dentists, and what is really true  
cannot afford to send them to the dentist which I know for  
a fact because I was told so by several people, and some of  
them are not really dentists. It is very easy to fill a  
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the dentists, not just so-called, get their eyeglasses.  
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1 Now then going on to the matter of payment.  
2 You have the statement before you, I won't read all this again,  
3 but it boils down to this -- let's put it this way: I know  
4 all the arguments for all kinds of graded scale. It is said  
5 that we charge the millionaire and poor man the same for a  
6 pound of coffee or a steak. This is true. But if the poor  
7 man cannot afford a steak every day, or even every week, he  
8 can buy something less expensive. If he cannot afford a pound  
9 of coffee, maybe he can afford a pound of tea which I believe  
10 is cheaper. We have our choice but when one comes to health  
11 you have no choice. If the poor man needs penicillin, or  
12 he has to have his tonsils out, he has to have them out  
13 and pay whatever the medical profession charges, just the  
14 same as applies to the millionaire.

15 When I say "poor man" I am not referring to  
16 the indigent. This is important, because as we heard before  
17 the indigent appears to be taken care of now. There are  
18 various ways of looking after indigents. It is not true.  
19 It is not the rich, the very rich, it's the people in between  
20 that do not qualify for free aid, for free medical aid and  
21 that are not wealthy enough to pay for this themselves. These  
22 are the people who earn from about \$3,000 up to \$5,000 or  
23 \$6,000. They are really in bad shape when it comes to  
24 providing for their medical care that they require.

25 Now I suggest here that either the premiums should



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1 be geared to our incomes, even as it is done in connection  
2 with income tax or else that the Government should pay a  
3 basic subsidy and then a lower premium rate should be charged  
4 across the board. Of course, we do not know what the premium  
5 is going to be. As I pointed out here we have a pretty rough  
6 idea what it will be. In short, my basic contention is it is  
7 time that we put first things first. For some strange reason  
8 in our society health comes last. Dental care comes last.  
PB/RPS 9 It isn't even thought of at all.

10 We have everything else, free education, which  
11 is important, but not nearly as important as health. Highways,  
12 parks, defence -- there is money for everything, everything  
13 but not for a poor child's rotten teeth or any other trouble  
14 that might arise in that child's body. I say let us put first  
15 things first, and first of all provide health care, and  
16 universal and comprehensive health care for our citizens,  
17 and then if you have any money left pay for the rest.

18 With your permission, Mr. Chairman and ladies  
19 and gentlemen, I forgot this I must confess but it is only  
20 going to take me a minute. I would like to make this verbal  
21 statement. Would you in your final report please remember  
22 that these benefits should be paid to residents of Ontario  
23 no matter where they happen to be at the time in the world.  
24 I myself have Medicall for my family, not for myself. I didn't  
25 figure I could afford it. The rest of my family is insured.





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1 They only pay benefits if my family happens to be in Ontario.  
2 If they make a trip to Ohio or anywhere else in the world we  
3 are not covered. I don't have to argue this. It is common  
4 sense if we pay premiums we should be covered anywhere in the  
5 world. Thank you.

6 THE CHAIRMAN: Thank you Mr. Wipprecht. It  
7 is quite apparent you are quite sincere in what you have said  
8 here and in your brief. Undoubtedly you have been here and  
9 heard the questions directed to the previous delegations.  
10 I would like to draw your attention to this, that the Enquiry  
11 has already received a delegation from the optometrists, from  
12 the dentists, from the Ontario Association of Social Workers,  
13 from the United Auto Workers who put forward a plea for universal  
14 coverage for everything. I think practically everything that  
15 is covered in your brief here has already been presented to  
16 the Enquiry by those associations representing the different  
17 groups who have the same interest, but in a specific field, that  
18 you have indicated here. If the questions are less than you  
19 might expect you will understand the reason. Are there any  
20 questions from the members of the Enquiry?

21 DR. HAMILTON: I might ask you, you come from  
22 an area where I believe there is not a great deal of industry  
23 and where there is probably a considerable population which  
24 falls into the group that might be described as medically  
25 indigent. You said the group in between who can't afford to pay



They can't say anything if they happen to be in Canada.  
If they make a mistake in their report, it is their  
responsibility. I don't want to say that. It is  
more of a general statement. It is covered  
world. Thank you.

THE CHAIRMAN: Thank you Mr. Wipprecht. It

is quite apparent you are quite sincere in what you have said.  
I am sure in your heart. Unintentionally you have been told  
heard the questions directed to the previous delegations.  
I am sure you are not going to say that they are  
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the hospital, from the medical association of Ontario, from  
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might expect you will understand the reason. Are there any

questions from the members of the Endury?

DR. HAMILTON: I might ask you, you come from  
an area where I believe there is not a great deal of industry  
and where there is a large population.  
I am sure that you are not in a position to  
indicate that you are not in a position to





1 for the health services they need. Which parts of health service  
2 cause the most hardship, which parts?

3 REV. WIPPRECHT: In my particular area?

4 DR. HAMILTON: In your area?

5 REV. WIPPRECHT: Well, I would be tempted to  
6 say dental care, as I see it.

7 DR. HAMILTON: Dental care causes more hardship?

8 REV. WIPPRECHT: Not only for the reason I  
9 indicated but also there seems to be a terrific shortage of  
10 dentists.

11 DR. HAMILTON: Because it isn't available.

12 REV. WIPPRECHT: Which may or may not be a  
13 matter for this Enquiry to discuss. This is a great problem.  
14 Also on account of inability to pay.

15 DR. HAMILTON: Are the services of a physician  
16 available?

17 REV. WIPPRECHT: Oh, yes.

18 DR. HAMILTON: Have people in your area suffered  
19 from not being able to get services of a physician?

20 REV. WIPPRECHT: No, not the way you put the  
21 question. I believe there isn't a doctor that would turn any-  
22 body down whether or not they could pay. That is not the point.  
23 We shouldn't have to go crawling to anybody and beg for  
24 treatment or anything else. We should be able to pay for what  
25 we get and the doctors should be able to collect.



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Also on account of inability to pay.

DR. HAMILTON: Are the services of a physician

available?

DR. HAMILTON: Have people in your area suffered

from not being able to get services of a physician?

REV. WIPRECHT: No, not the way you put the

question. I believe there isn't a doctor that would turn any-

body down whether or not they could pay. That is not the point.

We shouldn't have to go crawling to anybody and beg for

we get and the doctors should be able to collect.



1 DR. HAMILTON: What I am trying to get at is  
2 some idea of the relative importance of physicians' services,  
3 dental services, the cost of drugs and other health services  
4 in your area.

5 REV. WIPPRECHT: There are many more medical  
6 doctors than there are dentists in the area so I would say it  
7 is much easier to get medical treatment than dental treatment  
8 no matter what way you look at it.

9 THE CHAIRMAN: Mrs. Aylen?

10 MRS. AYLEN: I read this with great sympathy.  
11 I think your presentation covered a lot of things I would have  
12 asked you. There is one thing: as a user of medical services  
13 do you think the Ontario Hospital Services Commission is a  
14 pretty comprehensive plan? Would you like to have something  
15 out of the hospital that is comparable to what you get in  
16 the hospital?

17 REV. WIPPRECHT: Yes. The hospital plan we  
18 have now is pretty comprehensive in the area that it is supposed  
19 to serve including even such things as drugs and X-ray. Yes,  
20 the answer is yes.

21 MRS. AYLEN: Do you think the people in your  
22 community can afford that premium? Do they afford it, the  
23 premium for the Ontario Hospital Services Commission?

24 REV. WIPPRECHT: Yes, I think most people have  
25 that.





DR. HAMILTON: What I am trying to get at is  
not only of the extensive department of physicians' services,  
general services, but also of the other medical services  
in your area.

REV. WIPERONT: There are many more medical  
services than there are in the area. I would say it  
is not easier to get medical services than in other areas  
no matter what way you look at it.

THE CHAIRMAN: Mrs. Allen?

MRS. ALLEN: I read this with great sympathy.  
I think your presentation covered a lot of things I would have  
asked you. There is one thing: as a user of medical services  
do you think the Ontario Hospital Services Commission is a  
better organization than you have mentioned  
out of the hospital that is comparable to what you get in  
the hospital?

REV. WIPERONT: Yes, the hospital is  
not a better organization than the hospital is. It is  
not a better organization than the hospital is. It is  
the answer is yes.

MRS. ALLEN: Do you think the people in your  
community can afford that premium? Do they afford it, the

REV. WIPERONT: Yes, I think they can afford it.



1 MRS. AYLEN: In your community you think a  
2 large percentage do?

3 REV. WIPPRECHT: Yes.

4 MRS. AYLEN: There is one item, the financing  
5 of the plan isn't on an equitable basis. Would you give me  
6 your answer to that again. Maybe it is in your brief?

7 REV. WIPPRECHT: As I understand the proposed  
8 legislation there is going to be one premium charged to whoever  
9 wants to purchase the insurance. Now, supposing we say it  
10 is going to be \$150 give or take a few. That means a million-  
11 aire would have to pay \$150 and the man who makes \$3,000 and  
12 has, perhaps, ten children would have to pay \$150. It is  
13 not a problem to the millionaire. He makes \$7,000 a year but  
14 the man who makes only \$3,000 and has to support children, he  
15 might not be able to afford this.

16 MRS. AYLEN: You are suggesting it should be  
17 geared to salary?

18 REV. WIPPRECHT: Either that like our income  
19 tax is geared to salary or else the Government should pay a  
20 general subsidy to the private carriers taken out of consolidated  
21 revenues and then charge a more reasonable or lower rate, say  
22 maybe \$60, something like the hospitals. I pay \$5.60 for three  
23 months. That isn't bad. I pay \$180 a year to cover my whole  
24 family through Medicall and that would include any dental  
25 expenses or drugs. Either one or the other -- I would suggest either



MRS. AYLMER: In your community you think a

REV. WIPRECHT: Yes.

MRS. AYLMER: There is one item, the financing

of the plan isn't on an equitable basis. Would you give me

your answer to that again. Maybe it is in your brief?

legislation there is going to be one premium charged to whoever

wants to purchase the insurance. Now, supposing we say it

is going to be \$100 a year. That means a million-

aire would have to pay \$150 and the man who makes \$8,000 and

has, perhaps, ten children would have to pay \$150. It is

not a problem to the millionaire. He makes \$2,000 a year but

the man who makes only \$3,000 and has to support children he

might not be able to afford this.

MRS. AYLMER: You are suggesting it should be

geared to salary?

REV. WIPRECHT: Rather than like our income

tax is geared to salary or else the Government should pay a

general subsidy to the private carriers taken out of consolidated

revenues and then charge a more reasonable or lower rate. Say

maybe \$60, something like the hospitals. I pay \$25.00 for three

months. That isn't bad. I pay \$180 a year to cover my whole

family through Medical and that would include my dental

expenses or drugs. Either one or the other -- I would suggest it





1 subsidies or to be geared to income.

2 MR. CASWELL: Mr. Wipprecht, I would say I  
3 am sure we all want to express our appreciation to you for  
4 your personal sacrifice, I am sure, in coming down here because  
5 you were concerned with the people in your area. I would like  
6 to mention one thing, your concern about graduated rate for  
7 fees. There is considerable thought being given to endeavouring in  
8 some manner or form to subsidize the lower income bracket, the  
9 bracket above the indigents such as you are suggesting. There  
10 hasn't been any concrete proposal as to how this could be  
11 worked out. It is certainly in the mind of the Government  
12 and of the Commission.

13 REV. WIPPRECHT: I am glad to hear that.

14 MR. NAYLOR: I just wanted to comment on your  
15 statement about the premium rates. You made reference  
16 to them right now and it is also in your brief. You  
17 assumed that the cost per family might be around \$180 a  
18 year. That figure may be somewhere in the right area for  
19 the maximum premium, but the plan contemplates maximum rates  
20 for those that are old or sub-standard in health. Healthy  
21 people, or young people, will presumably be able to buy for  
22 substantially lower premiums. This would be probably about the  
23 maximum rate for a family of three. A family of two, such as  
24 an elderly couple, the maximum rate would be substantially lower  
25 so the cost, I guess, from what I have been of estimates, would



submitted on to be passed to the

Mr. [Name] [Address] [City] [Province] [Postal Code]

and we all want to express our appreciation to you for

your personal sacrifice, I am sure, in coming down here because

you were concerned with the people in your area. I would like

to mention one thing, your concern about the people who

live there is commendable. I think that is a very good thing.

Some manner of form to submit the lower income people, the

bracket above the indigents and as you are a [Name], it is

hasn't been any concrete proposal as to how this could be

worked out. It is certainly in the mind of the Government

and of the Commission.

MR. WATSON: I am glad to hear that.

MR. WATSON: I have wanted to come to this

statement about the pension rates. You made reference

to them right now and it is also in your report.

assumed that the cost per family might be around \$100 a

year. That figure may be somewhat in the range of \$100

the maximum pension, but the plan contemplates a number of

for those that are old or infirm or disabled.

people, or young people, will necessarily be able to pay for

substantially lower pensions. That would be probably about the

maximum rate for a family of three. A family of two, and so

an elderly couple, the maximum rate would be substantially lower

the cost, I guess, from what I have heard or estimated, would



1 be quite a bit lower in many instances.

2 REV. WIPPRECHT: Do you mean under the proposed  
3 legislation?

4 MR. NAYLOR: That is right; under the proposed  
5 plan.

6 REV. WIPPRECHT: This isn't my field, but  
7 it just makes no sense at all. If a company like Continental  
8 the Medicall, has to charge that much an individual and they  
9 give the best coverage that anybody can get today, and presumably  
10 still make a small profit and they, I assume, try to get it as  
11 low as possible, if they have come to the conclusion with their  
12 statistics that this has to be charged at \$180, how can anybody  
13 else -- and let us not forget it is supposed to be run by  
14 private carriers, not government, so that always they come out on  
15 top. How can anybody come out with a statement saying this is  
16 going to be cheaper if Medicall or Continental figures it has  
17 got to be \$180 or it won't work.

18 MR. NAYLOR: For one thing, they don't ask for  
19 examination and they don't create rates by age. What I am  
20 saying is people that are healthy can submit a certificate of  
21 health or someone under age 40 can obtain a substantially lower  
22 premium.

23 REV. WIPPRECHT: Are you talking about the  
24 proposed legislation?

25 MR. NAYLOR: That is right. I am saying there





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saying is people that are healthy can submit a certificate of

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premium.

REV. WIPRECHT: Are you talking about the

proposed legislation?

MR. NAYLOR: That is right. I am saying there



1 will be maximum premiums for everybody. The carriers can't  
2 charge more than the stipulated maximum which will probably  
3 be somewhere in the area of \$180 per family. People that are  
4 in good health and are younger ages will be able to get rates  
5 considerably lower.

6 REV. WIPPRECHT: The point, then, is that  
7 the schedule of premiums won't be geared to income but to  
8 the state of health. I have a son, a boy in my family,  
9 who has a pre-existing condition and the Medical was the only,  
10 and just recently, company that would help me at all. If it  
11 hadn't been for that I would have made a few other points in  
12 my presentation. I happen to have had luck, a sick boy in  
13 the family. I now understand because of this circumstance I  
14 will have to pay a much higher premium than, say, my next-door  
15 neighbour, who is not unfortunate now but he might have a  
16 chronic case in the family next week. Because he got in a week  
17 ahead he is going to be stuck with a low premium and I am going  
18 to get stuck with the high premium, and I make less money, and it  
19 is just because I have a sick boy. Is this the way it is going  
20 to be worked out?

21 MR. NAYLOR: To some extent, but if you only  
22 had one child in the family that was so afflicted it might  
23 not matter.

24 REV. WIPPRECHT: Supposing I had two or three?  
25 To me this is a wrong way of doing it. The Bible says the strong



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REV. WIPREIGHT: Supposing I had two or three?





1 shall bear the burdens of the weak, not the other way.

2 MR. NAYLOR: That is why there is a maximum  
3 premium setting a ceiling beyond which they won't be charged.

4 THE CHAIRMAN: Then there is the possibility  
5 of subsidy also. Are you finished?

6 MR. NAYLOR: Yes.

7 MR. COULTER: Mr. Chairman, Reverend sir, I  
8 think you and I can see eye to eye, that only two groups of  
9 people can afford to be sick, the very poor and the very rich.  
10 Those of us in between can't afford it. I was just wondering,  
11 sir, have you any idea what the average income might be in  
12 your particular area?

13 REV. WIPPRECHT: I would say about \$3,500 give  
14 or take a few dollars, in the neighbourhood of \$4,000.

15 MR. COULTER: You have already stated there  
16 is a shortage of dentists. In your school system or area is  
17 there any travelling clinic that tests eyes or anything like  
18 that? How are your school children in that particular area?  
19 Are they being looked after in that particular sense?

20 REV. WIPPRECHT: To my knowledge the answer is  
21 no with two exceptions. Temagami had a Red Cross coach out  
22 two years ago which stayed for about a year and fixed all the  
23 teeth of all the children free -- not free, somebody had to  
24 pay. Then we have a health unit which conducts occasional  
25 clinics mainly for the purpose of giving inoculations and shots.



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think you and I can see eye to eye, that only two, three or

people can afford to be sick, the very poor and the very rich.

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REV. WIPRECHT: I would say about \$3,000 a year

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two years ago which stayed for about a year and fixed all the

teeth of all the children free -- not free, somebody had to

pay. Then we have a health unit which conducts occasional

clinics mainly for the purpose of giving inoculations and shots.



1 These are free too. Again they come out of somebody's pocket,  
2 municipal tax. Apart from that, I have two children going to  
3 school and I have never been aware of any doctor going to the  
4 school or checking eyes or teeth or anything. I believe those  
5 two things that are being done.

2 6 MR. COULTER: I can understand the problem  
7 because I have knowledge of some of the outlying districts.  
8 I can understand the problem. I think something should be  
9 done in some lines, say young people, particularly school  
10 children, their eyes should be examined. I don't think I  
11 have further questions outside of the fact I would like to  
12 commend you on your interest in your fellow man, and I think  
13 you are on the right track.

14 THE CHAIRMAN: Any further questions, Mr.  
15 Coulter?

16 Any further questions? Do you have any further  
17 statement?

18 REV. WIPPRECHT: Once again I appreciate the  
19 privilege of being here and I would like to repeat this last  
20 point. I haven't read about it anywhere else. We didn't put  
21 it in my written statement, but it is most important this plan  
22 be made world-wide. Some of us get sick in Hong Kong and  
23 anywhere else in the world and we should be covered by this  
24 proposed plan through some private carrier. I would suggest  
25 that this be given most serious consideration. Thank you.





There are two main things that are being done. One is the school or checking eyes or teeth or anything. And the other is the school and I have never been aware of any doctor going to the municipal tax. Apart from that, I have two children going to school.

MR. CHAIRMAN: I can understand the problem. Because I have knowledge of some of the outlying districts. I can understand the problem. I think something should be done in some lines, say young people, particularly school children, their eyes should be examined. I don't think I have further questions outside of the fact I would like to commend you on your interest in your fellow man, and I think you are on the right track.

THE CHAIRMAN: Any further questions, Mr. ...

Any further questions? Do you have any further ...

MR. WINTHROP: On this point I appreciate the privilege of being here and I would like to repeat this point. I haven't read about it anywhere else. We didn't put it in my written statement, but it is most important that it be made world-wide. Some of us get sick in Hong Kong and anywhere else in the world and we should be covered by this proposed plan through some private carrier. I would suggest that this be given most serious consideration. Thank you.



1 THE CHAIRMAN: Thank you very much.

2  
3 ---Whereupon the hearing was adjourned until 10:00 a.m.,  
4 Wednesday, the 22nd day of January, 1964.

5 \* \* \* \* \*



\* \* \* \* \*







